COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
COMMITTEE REPORT
1350 Pennsylvania Avenue, NW, Washington, D.C. 20004

TO: Members of the Council of the District of Columbia

FROM: Christina Henderson, Chairperson
Committee on Health

DATE: May 31, 2023

SUBJECT: B25-0034, the "Expanding Access to Fertility Treatment Amendment Act of 2023"

The Committee on Health, to which the Bill 25-0034, the "Expanding Access to Fertility Treatment Amendment Act of 2023" was sequentially referred, reports favorably on the legislation and recommends approval by the Council of the District of Columbia.

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I. BACKGROUND AND NEED

Bill 24-699, the "Expanding Access to Fertility Treatment Amendment Act of 2022", was introduced on February 28, 2022, by Councilmembers Henderson, Cheh, Nadeau, Bonds, and Allen, and co-sponsored by Councilmember Lewis George. The bill was re-referred to the Committee on Business and Economic Development with comments from the Committee on Health on April 5, 2022. The Committee on Business and Economic Development held a public hearing on the bill on October 25, 2022.

The bill was re-introduced in Council Period 25 as Bill 25-34, the "Expanding Access to Fertility Treatment Amendment Act of 2023" on January 13, 2023, by Councilmembers Henderson, Lewis George, McDuffie, Allen, Nadeau, Parker, R. White, Frumin, and Pinto, and co-sponsored by Councilmember Bonds. The bill was sequentially referred to the Committee on Business and Economic Development and the Committee on Health on January 17, 2023.

The legislation would expand health insurance coverage in the District of Columbia provided through private insurers, Medicaid, and the DC Healthcare Alliance to include diagnosis and treatment for infertility. As introduced, the legislation prohibits health insurers from imposing additional costs or certain limitations on coverage and from placing pre-existing condition exclusions or waiting periods on coverage.

Clinically, infertility is defined as an individual being unable "to achieve pregnancy after one year of having regular, unprotected intercourse, or after six months if the woman is over 35 years of age."[1] However, 20 states have expanded upon this definition to be more inclusive and reflective of the actual difficulties surrounding fertility. This bill also seeks to expand this definition by removing onerous requirements to prove infertility and allow for a licensed physician to be able to determine infertility based on a patient's medical history, sexual history, reproductive history, age, physical findings and/or diagnostic testing. It is the Committee's view that being inclusive of the LGBTQIA[2] population and those with medical and/or physical conditions that inhibit them from having children, is necessary.

Infertility is a prevalent issue that affects thousands of people nationally and in the District. According to the National Institutes of Health, about 9% of men and 11% of women of reproductive age in the U.S. experience fertility issues.[3] Despite the prevalence of infertility, people with this medical condition receive less support from their insurance than people with other conditions of similar or lesser prevalence. Insurance providers often market their approaches to treating a range of medical conditions such as cancer (9.8%), kidney disease (2.4%), and heart

[1] "Infertility and Fertility," National Institute of Health. https://www.nichd.nih.gov/health/topics/factsheets/infertility

[2] LGBTQIA means Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Asexual.

[3] "Infertility and Fertility," National Institute of Health. https://www.nichd.nih.gov/health/topics/factsheets/infertility

disease (4.9%), to name a few that affect similar or even fewer number of people. Asthma affects approximately 8% of adults in the United States and is covered by the vast majority of insurers.[4]

Currently, in vitro fertilization (IVF) is the most effective assisted reproductive technology available to patients experiencing infertility. IVF is a procedure in which mature eggs are retrieved from ovaries and fertilized by sperm in a lab. After the retrieval and fertilization, a fertilized egg (embryo) or multiple embryos, are transferred to a uterus. The IVF process can vary based on the needs of a patient. For example, there are instances when individuals pursue gestational surrogacy in which the embryo is transferred to a third party. This can be needed for a variety of reasons, such as women who have medical conditions that do not enable them to carry a pregnancy or members of the LGBTQIA population who wish to build their families. Insurers have been known to deny coverage for embryo transfers, a process that costs on average between $3,000-$5,000.[5]

While other fertility treatments exist such as medication or intrauterine insemination (IUI), they have lower success rates and are used often as a first step in fertility treatment before IVF is recommended. The average cost of IUI treatment is approximately $1,000, however the individual success rate for IUI is 15% to 20%. In contrast, while a female's age is the primary indicator of how successful an IVF cycle will be, studies have shown that the live-birth rate for the first cycle of IVF treatment was 29.5%, with an increasing likelihood of a live-birth with multiple cycles—above 65% for all women, and even higher for women within certain age ranges.[6]

The cost of diagnosis and treatment is so high that IVF is often not feasible for many people. The average cost of a single IVF cycle in the District ranges from $10,500 to $12,625 depending on the clinic that an individual selects.[7] Approximately 80% of people who underwent IVF fertility treatments in 2018 had hardly any or no insurance coverage at all.[8] When factoring in that the average patient will undergo 2.3-2.7 IVF cycles, it should come as no surprise that many incur debt when undergoing this process.[9] Costs for an IVF cycle in the United States on average are significantly higher than in other countries. While this is true for health care costs overall, IVF has such high costs for the patients due to lack of any insurance coverage for any portion of the procedure. In the United Kingdom and Australia, for example, the cost of IVF is closer to $5,000.

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[4] "Asthma," National Center for Health Statistics, Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/asthma.htm

[5] Rachel Gurevich, "How Much Does IVF Really Cost?," Very Well Family September 17, 2022. https://www.verywellfamily.com/how-much-does-ivf-cost-1960212#

[6] Andrew D.A.C. Smith, Kate Tilling, Scott M. Nelson, "Live-Birth Rate Associated with Repeat In Vitro Fertilization Treatment Cycles," American Medical Association, December 22/29, 2015. https://jamanetwork.com/journals/jama/fullarticle/2478204

[7] "D.C. Fertility Clinics." IVF Options, https://ivfoptions.com/d-c/d-c-d-c/

[8] FertilityIQ, "2021 FertilityIQ Workplace Index." https://www.fertilityiq.com/topics/fertilityiq-data-and-notes/fertilityiq-workplace-index

[9] "Using AI to Predict a Viable Pregnancy during IVF," Lifesciences Intelligence, November 2, 2022. https://lifesciencesintelligence.com/features/using-ai-to-predict-a-viable-pregnancy-during-ivf#:~:

In Canada, costs are on average about $8,500, but still well below the average cost in the United States.[10] In a 2015 survey, nearly 70% of those surveyed in the United States incurred some degree of debt from their fertility treatments.[11] Sadly, as a result, 34% of women stop treatment because of unaffordability.[12]

Questions of equity also arise when discussing IVF. Despite the fact that studies have found that Black and Latina women are more likely to experience fertility challenges than white women, women of color are less likely to seek treatment.[13] According to the U.S. Centers for Disease Control and Prevention, only 8% of Black women ages 25 to 44 seek medical help to become pregnant, in contrast to 15% of white women doing so.[14] Women of color, for example, have reported that "some physicians brush off their fertility concerns, assume they can get pregnant easily, emphasize birth control over procreation, and may dissuade them from having children."[15] The out of pocket costs are also a deterrent. In the District, the Black median household income is $45,200, meaning that just one cycle of IVF can cost more than 25% of household income, before taxes.[16] In contrast, the white median household income in the District is $142,500.[17]

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[10] James F. Smith, Michael L. Eisenberg, David Glidden, Susan G. Millstein, Marcelle Cedars, Thomas J. Walsh, Jonathan Showstack, Lauri A. Pasch, Nancy Adler, Patricia P. Katz, "Socioeconomic disparities in the use and success of fertility treatments: analysis of data from a prospective cohort in the United States," Science Direct, May 25, 2022. https://doi.org/10.1016/j.fertnstert.2011.04.054

[11] "Fertility Treatments in the United States: Sentiment, Costs and Financial Impact," Prosper, May 20, 2015. https://www.prosper.com/blog/fertility-treatments-in-the-united-states-sentiment-costs-and-financial-impact/

[12] The Ethic Committee of the American Society for Reproductive Medicine, "Disparities in access to effective treatment for infertility in the United States: an Ethics Committee Opinion," *American Society for Reproductive Medicine*, July 2021. https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf

[13] "Infertility and BIPOC (Black, Indigenous & People of Color) Women." American Psychological Association. https://www.apa.org/pi/women/committee/infertility-bipoc

[14] "Infertility Service Use in the United States: Data from the National Survey of Family Growth, 1982–2010 2014," Center for Disease Control and Prevention. www.cdc.gov/nchs/data/nhsr/nhsr073.pdf

[15] Ann V. Bell, "Beyond (financial) accessibility: inequalities within medicalization of infertility," Sociology of Health & Wellness, May 20, 2010. https://doi.org/10.1111/j.1467-9566.2009.01235.x

[16] Samantha Schmidt, "Wage gap robs Black women in D.C. of almost $2 million over lifetime, analysis finds," The Washington Post, July 29, 2020. https://www.washingtonpost.com/dc-md-va/2020/07/29/black-women-pay-gap-dc/

[17] *Ibid.*

As of June 2022, 20 states have passed fertility insurance coverage laws, with 14 of those laws including IVF coverage, and 12 of those with fertility preservation laws.[18] The ranges and specifications of coverage vary state by state with some, like Maryland, covering the cost of three IVF cycles and fertilization preservation.[19] The Committee heard testimony about how these insurance changes in other jurisdictions led to some District residents moving to neighboring states with coverage or taking jobs with companies who offer this coverage as part of their benefits. The Expanding Access to Fertility Treatment Act would bring the District in close alignment with the 12 states who offer the most comprehensive IVF insurance coverage in the country.

In contrast to the expansion of IVF coverage in the private health insurance market, no state has yet expanded Medicaid policies to provide full IVF coverage. New York provides the most expansive Medicaid coverage policy, including coverage for diagnosis of infertility and ovulation-enhancing medication therapy. This is a first-line treatment for infertility to stimulate higher quality eggs or a greater quantity of eggs. This bill will align the District's Medicaid and Alliance coverage with New York's as the most expansive coverage for fertility treatment in the country. Further, this bill requires the District's Department of Health Care Finance (DHCF) to consult with the Centers for Medicare & Medicaid Services (CMS) to determine the possibilities for expanding Medicaid and Alliance coverage to the full range of fertility treatments including IVF. DHCF is required to report back to the Council with their findings within 180 days.

During the hearing on this legislation, Associate Commissioner Philip Barlow of the Department of Insurance, Securities, and Banking, mentioned that DISB did not know at the time what the cost attributable to the new mandate would be. However, statistics from other states who have passed IVF insurance coverage laws point to a minimal impact on increased premiums for patients. An analysis done on a similar bill in California showed a premium increase per member per month of $0.92 for state-run plans and $4.99 for private insurance.[20] Similarly, data from Massachusetts, Connecticut, and Rhode Island, who have been mandating infertility benefits for over 30 years, estimate the cost of infertility coverage to be less than 1% of total premium costs.[21]

In subsequent conversations with DISB, it became clear that more time would be needed for private health insurance plans to implement the IVF coverage requirement, so the effective date of such requirement was moved back one year to begin January 1, 2025. Further, this will allow time for DISB to complete an actuarial assessment to determine the fiscal impact of the bill.

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[18]The National Infertility Association, "Insurance Coverage by State," Resolve. https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/

[19] *Ibid.*

[20] "Analysis of California Assembly Bill 2781 Treatment of Infertility," California Health Benefits Review Program, April 3, 2020. http://analyses.chbrp.com/document/view.php?id=1482

[21] Gabriela Weigel, Usha Ranji, Michelle Long, Alina Salganicoff, "Coverage and Use of Fertility Services in the U.S.," Kaiser Family Foundation, September 13, 2020. https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/

The "Expanding Access to Fertility Treatment Act" would alleviate the concerns of so many people in the District who have struggled with infertility and hope to start a family of their own.

II. COMMITTEE PRINT CHANGES

The Committee Print makes several changes from the introduced version after feedback from stakeholders during the hearing on the bill and in follow-up conversations. First, the Committee Print expands the definition of infertility to include anyone who is unable to establish a pregnancy for a variety of reasons. This new definition is consistent with other jurisdictions that have passed similar legislation.

The Committee Print also adds standard fertility preservation services as a procedure for which insurance companies must provide coverage. Fertility preservation is defined as the process of saving or protecting eggs, sperm, or reproductive tissue so that a person can use them to have biological children in the future.[22] Currently, there are 12 states that have enacted fertility preservation laws.[23] Without including fertility preservation coverage, persons who have a medical condition who are expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment, could risk future infertility. It is the Committee's view that a medical condition should not preclude someone from being able to pursue the chance of having children. Having fertility preservation services covered by insurance would help these individuals with the costs associated with doing so. For context, according to the Alliance for Fertility Preservation, egg or embryo freezing can cost between $10,000-$15,000 and anywhere between $300-600 per year for storage.[24]

Third, the Committee Print specifies that coverage must include at least three complete oocyte (egg) retrievals with unlimited embryo transfers from those retrievals. This would create a floor for required insurance coverage, but still provide a viable chance for an individual to pursue IVF and have multiple chances at a pregnancy. The introduced version of the bill did not include a set number of required retrievals, but the Committee believes this change is appropriate and aligns with most other jurisdictions that provide this coverage, including neighboring Maryland, New York, and Colorado. While Maryland and several other states also include a monetary cap, the print does not include one as costs could increase, and thus reduce the benefit provided over time. Further, the Committee Print clarifies that insurance must at least cover unlimited transfers

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[22] "What is fertility preservation?" National Institute of Health. https://www.nichd.nih.gov/health/topics/infertility/conditioninfo/fertilitypreservation

[23] The National Infertility Association, "Insurance Coverage by State," Resolve. https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/

[24] "How much does fertility preservation cost?" Alliance For Fertility Preservation. https://www.allianceforfertilitypreservation.org/paying-for-treatments/

from the minimum three covered retrievals. If an individual enrollee decides to self-fund additional retrievals beyond those mandated to be covered, this bill would not require insurance plans to cover additional transfers from the retrievals beyond the three covered under the mandate. However, insurance plans would have the freedom to expand coverage further for additional retrievals or additional transfers. Additionally, the Print includes transfers from oocyte retrievals performed prior to January 1, 2025 in order to prevent individuals from undergoing a new taxing retrieval process to get the transfer covered and to cover individuals who have used fertility preservation services prior to that date.

Further, the Committee Print includes language to enable coverage for transfer of an embryo to a third-party during the IVF process. More specifically, this means that an insured enrollee who needs a surrogate would be covered for an embryo transfer to a third-party surrogate. To be clear, this language would not cover the pregnancy of the surrogate and so coverage would stop after a successful embryo transfer procedure. The impetus behind including this provision is to ensure that, for example, LGTBQIA couples or individuals who are unable to carry a pregnancy, would be covered. There have been instances in other states in which insurers have denied IVF coverage for the transfer of an embryo to a third party and this language would ensure that this does not happen in the District. The bill only covers the medical care up to and including the transfer of the embryo to the surrogate. The bill does not cover non-medical expenses related to surrogacy and does not cover the surrogate's medical expenses occurring after the embryo transfer procedure.

The Committee Print further separates the private health insurance plan requirements from the expansion of coverage under Medicaid and the Alliance. Under private health insurance plans, this bill mandates coverage for the described fertility services including IVF and standard fertility preservation services. Under Medicaid and the Alliance, the bill will require coverage for diagnosis of infertility and ovulation enhancing medication treatment, matching New York as the most expansive fertility care coverage in the country. The bill further directs DHCF to consult with CMS to determine how coverage can be further expanded to include IVF and standard fertility preservation services under Medicaid and the Alliance. While the Committee hoped to extend full coverage including IVF and standard fertility preservation services for Medicaid and Alliance enrollees, the fact that no state had done so before meant that there were unresolved issues of whether such services would be considered medically reasonable and necessary under federal law. If these fertility services were not medically reasonable and necessary, then the federal government would not contribute to the funding for the services. Therefore, the Committee directed DHCF to work with CMS to determine how full fertility services could be covered in a way that would receive federal matching dollars. Another consideration is that because Medicaid does not currently cover these fertility services, specialists in the field generally are not enrolled in the Medicaid program and therefore cannot currently charge Medicaid for services provided to enrollees. This would mean that even if coverage were extended, enrollees would have severely limited access to providers willing to administer such services under the Medicaid program. The Committee looks forward to reviewing the report from DHCF to ensure coverage and to working with the provider community to ensure access to Medicaid-enrolled providers across the District.

Finally, the Committee Print adjusts date of the requirement for insurers to provide fertility coverage. The private insurance coverage requirement begins January 1, 2025, to allows insurers to have adequate time to conduct their actuarial analysis and submit their rates to DISB for review for the upcoming year and to allow DISB to complete its own actuarial assessment to determine the fiscal impact of the mandate. The Medicaid and Alliance coverage requirement will begin January 1, 2024.

Overall, the Committee Print for this bill reflects the testimonies at the hearing and establishes a more comprehensive insurance coverage for a wider range of individuals in the District who encounter issues with infertility.

III. LEGISLATIVE CHRONOLOGY

February 28, 2022	B24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022" was introduced by Councilmembers Henderson, Cheh, Nadeau, Bonds, and Allen at the Office of the Secretary.
March 1, 2022	B24-0699 was referred to the Committee on Health.
March 25, 2022	Notice of Intent to Act on B24-0699 Published in the *District of Columbia Register*.
March 25, 2022	Re-Referral published.
April 5, 2022	Re-Referred to Committee on Business and Economic Development with comments from the Committee on Health.
October 4, 2022	Notice of Public Hearing filed in the Office of Secretary.
October 7, 2022	Notice of Public Hearing Published in the *District of Columbia Register*.
October 25, 2022	Public Hearing on B24-0699.
January 13, 2023	B25-0034, the "Expanding Access to Fertility Treatment Amendment Act of 2023" was re-introduced by Councilmembers Henderson, Lewis George, Allen, Nadeau, McDuffie, Parker, R. White, Frumin, and Pinto at the Office of the Secretary.
January 17, 2023	Referred to Committee on Business and Economic Development, Committee on Health.

January 20, 2023	Notice of Intent to Act on B25-0034 Published in the District of Columbia Register.
May 16, 2023	Notice of Mark-up is filed in the Office of Secretary by the Committee on Health.
May 26, 2023	Notice of Mark-up is filed in the Office of Secretary by the Committee on Business and Economic Development.
May 31, 2023	B25-34 is marked up by the Committee on Business and Economic Development.
May 31, 2023	B25-34 is marked up by the Committee on Health.

IV. POSITION OF THE EXECUTIVE

On October 25, 2022, the Committee on Business and Economic Development held a public hearing on Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022". The Committee received testimony from Phillip Barlow, the Associate Commissioner at the Department of Insurance, Securities and Banking (DISB). Associate Commissioner Barlow testified that the Department is fully supportive of the Council's efforts to increase access to care. He noted that the new mandate, as a result of the passage of this legislation, would likely be a financial cost to the District specific to the ACA plans sold on DC Health Link in the individual and small group markets. DISB however, did not know at the time what the cost attributable to the new mandate would be. He also pointed out that the effective date of this new benefit would result in an inconsistency between the law and policy language for a period and that this would cause premiums to increase.

V. ADVISORY NEIGHBORHOOD COMMISSION

Trupti J. Patel, ANC 2A, SMD 03

ANC Commissioner Patel testified in support of the proposed measure. She mentioned that this legislation would make a difference for thousands of women who are D.C. residents and shared her own personal history with circumstantial infertility. Ms. Patel shared that when researching the cost of fertility treatment, that the financial price tags were not only incredibly high and were an impediment to pursue treatment, but also that the emotional price tag around infertility is something not often discussed. She concluded that she wished that the coverage this legislation extends, had been available to her.

VI. WITNESS LIST AND HEARING RECORD

Public Witnesses

Roy Ramthun, President, HSA Consulting Services, LLC

Mr. Ramthun submitted testimony for both B24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022," and the legislation pertaining to this committee report on behalf of the American Bankers Association Health Savings Account Council. He noted that B24-0831 creates unintended consequences for consumers and their employers that use Health Savings Accounts with their HSA-qualified plans. Mr. Ramthun points out that in contrast, B24-0699, does not raise similar concerns because it would only require health insurers to cover the diagnosis and treatment of infertility (including in vitro fertilization) with cost-sharing that is no different than cost-sharing for services not related to infertility. His organization interprets the bill to mean that health insurers are not required to cover these services without cost-sharing and may apply deductibles and other cost-sharing to the cost of diagnosis and treatment of infertility and that that is important for HSA-qualified plans because the IRS does not consider the diagnosis and treatment of infertility to be "preventive care" services.

Sara Imershein, Chair of the DC Section of the American College of Obstetricians and Gynecologists.

Dr. Imershein endorsed and supported the legislation but with several modifications. She pointed out that she is unaware of any insurance plan that pays for unlimited fertility treatments, given that IVF cycles are often limited because of the huge on-going expense. Dr. Imershein also mentioned that the bill does not address egg retrieval (or sperm collection) and storage for future use; nor does the bill address surrogacy or donor egg or donor sperm. She added that expanding access and coverage is good, but not with unlimited access. She said that sometime in the future there will be newer/better/safer procedures that will be denied to patients because the bill excluded technology in development. She concluded that the bill is a good start with a great goal but is not ready to be passed and enacted as written.

D.C. Catholic Conference

The D.C. Catholic Conference wrote in support of expanded access to infertility treatments and that this care should be accessible for all persons if it constituted *appropriate* infertility treatment. They point out that assisted reproductive technologies like in vitro fertilization contradict the dignity of the human person and are not without risk of medical complications to the women who undergoes the procedures. They also pointed out that they are thankful for the inclusion of a necessary religious exemption in this bill. They concluded that they hope that the Council will help couples experiencing infertility by promoting safe and affordable healthcare that affirms the dignity of both parents and children.

Joyce Reinecke, Executive Director of the Alliance for Fertility Preservation

Ms. Reinecke wrote on behalf of the Alliance for Fertility Preservation that they support the in vitro fertilization (IVF) coverage provisions but that they believe that the legislation should include coverage for patients who need to preserve their fertility out of medical necessity. She stated that some cancer treatments can cause iatrogenic infertility during treatments and that fertility preservation has been considered part of the standard of care for age-eligible cancer patients for more than fifteen years, and is recognized by all the relevant medical associations, including the American Society of Clinical Oncology (ASCO), the American Society for Reproductive Medicine (ASRM), and the American Medical Association (AMA). In conclusion, the organization applauded the consideration of this legislation but asked that it include coverage for patients who need to preserve their fertility out of medical necessity.

Georgette Kerr, Volunteer, RESOLVE: The National Infertility Association

Ms. Kerr submitted testimony in support of the proposed measure. She pointed out that she is one of the 1 in 5 people living in Washington D.C. who struggle with infertility. She discussed when she and her husband decided to pursue IVF, that they quickly learned that they had no access to health insurance that provided even partial coverage for fertility treatment. Only due to being fortunate enough to have the means to pay out of pocket for fertility treatment, she is now a mom because of IVF. She mentioned that testing, treatments, and medication have cost her family roughly $70,000 out of pocket, noting that this sort of investment is unfathomable for many families in the District, especially in today's economic environment. She ended her testimony urging the Committee and Council to pass this legislation.

Barbara Mitchell, Legislative Liaison, The Nation's Capital Chapter of Jack and Jill of America, Inc.

Ms. Mitchell wrote that this measure is extraordinarily important for District residents, particularly Black people and families. She mentioned that financial barriers, when removed or reduced, leads to an increase in use of fertility treatment by Black people; increased access may also address the shame of infertility; their Chapter mothers have benefited from access to fertility treatments and would like other people, specifically people of color, to benefit from this increased access; and that the Council should continue to research ways to ensure that fertility services are not fraught with challenges for Black people as other parenting and maternal healthcare services tend to be. The organization concluded their testimony remarking that they support the bill and know that this bill can address some of the financial and physiological reasons people, specifically Black people, do not seek fertility treatment in the first place.

Katy Bidwell

Ms. Bidwell submitted written testimony in support of the bill. She detailed her struggle with pursuing IVF due to the costs and it not being recognized as a medical necessity. Ms. Bidwell mentioned that she knows couples who have moved out of D.C. for this reason and feels it is unjust that affordable fertility care be only available to women who happen to live in a certain place or have a job that extends coverage for infertility. Lastly, she applauded the efforts of this bill to correct the inequities facing women in the District.

Ernie Davis, Regional Director of Government Affairs, The Leukemia and Lymphoma Society

Mr. Davis submitted testimony on behalf of the Leukemia and Lymphoma Society in support of the bill, requesting the addition of fertility preservation language. The organization noted that fertility preservation is an essential consideration for pediatric and young adult blood cancer survivors. They assert that no patient, or parents of a young patient, should be put into a position where they must weigh the additional costs of fertility preservation services that are only necessary because of their cancer treatment against the costs of the treatment itself.

Mary Calhoun

Ms. Calhoun wrote in as a D.C. employee and resident to express support for the legislation. She discussed her and her partner's need for IVF treatments for their second child and the emotional toll it took. Ms. Calhoun wrote that they needed three retrievals and three transfers, which would have cost them about $45,000 out of pocket, constituting more than half of her annual salary. She said that this cost would have led her and her family to have gone bankrupt but didn't because of insurance coverage through her employer.

Paul Celano, President, Maryland/DC Society of Clinical Oncology

Mr. Celano submitted testimony on behalf of The Maryland/District of Columbia Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) to urge the Committee to add fertility preservation coverage. MDCSCO and ASCO advocate for coverage of embryo, oocyte and sperm cryopreservation procedures for an insured patient who is at least eighteen years of age and has been diagnosed with cancer but has not started cancer treatment.

Maya Cadogan, Ward 4 Resident, Founder and Executive Director of PAVE (Parents Amplifying Voices in Education)

Ms. Cadogan submitted testimony to urge the Council to address what she said is a racial justice issue that is disproportionately impacting families, especially Black families like her own. She discussed her own struggle with infertility and the need for three rounds of IVF to conceive her

first child. She stated that Black women are more than twice as likely to suffer from infertility as compared to white women and that infertility treatment is cost prohibitive to most Black women and families. Ms. Cadogan had to weigh either buying a house or fund IVF and is thankful that her husband's employer is based in New York, and his insurance provided her and her husband the option to pursue IVF, but had hoped that the option would have been available in Washington D.C.

Sarah N. Lynch, Ward 5 Resident

Ms. Lynch submitted written testimony to express support for the bill. She urged the consideration of several revisions that she believed would strengthen the legislation. The first pertains to banning the use of lifetime maximum caps on infertility insurance coverage, stating that infertility care should not be limited. The second is to prohibit specialty pharmacies, manufactures, and pharmacy benefit managers from charging higher prices to insured patients versus uninsured patients, a common practice that discourages patients from using insurance to cover the costs of their fertility drugs. The third would be to require insurance companies to cover the cost of preimplantation genetic testing for aneuploidies, a key test that can reduces the chances of miscarriages; this would also include the purchase of the eggs themselves as well as accompanying procedures including egg fertilization, biopsy, cryo-preservation, thawing, assisted hatching and embryo transfer. Finally, she asked for a ban on discrimination against single women and same-sex couples who wish to pursue fertility care.

Stephanie Oldano, D.C. Resident

Ms. Oldano testified in support of the bill and detailed her experience with infertility. She mentioned that while her partner is employed by a prominent D.C. environmental non-profit and she is a federal employee, that these treatments are not covered by their insurance and would cost them all their savings; this would thwart any chance at making a down payment on a house in the DMV. She asserted that fertility treatment is an essential medical treatment.

Tobin Van Ostern, Co-Founder, Savi Solutions PBC

Mr. Van Ostern submitted written testimony urging the passage of this legislation. He is the owner of a DC-based tech startup with nearly 30 employees. His company offers their employees insurance through the DC Exchange for small business and noted that due to the nature of the program, they are unable to specifically negotiate or add coverage for fertility treatment to their coverage. He concluded by saying that he thinks that this legislation would be a strong addition to the plans being offered.

Zo Clement, 8th Grade Inclusion Teacher

Mr. Clement provided written testimony asking that the bill be swiftly passed so that he and others in similar situations of dealing with infertility would be able to continue working in D.C. He stated that as a schoolteacher, he would like to remain in DC to teach, but since IVF coverage is provided in Maryland, that he has strongly debated whether to change jobs to move to Maryland. He had previously been told by his doctor that due to his age and genetic preconditions, that conception would be difficult and risky and that he should pursue IVF to build his family.

VII. IMPACT ON EXISTING LAW

B25-34 amends the Women's Health and Cancer Rights Federal Law Conformity Act of 2000 to require an individual or group plan to provide coverage for the diagnosis and treatment of infertility and standard fertility preservation services; to require a health insurer offering health insurance coverage through Medicaid and the D.C. Healthcare Alliance program to cover the diagnosis and medication treatment of infertility; to require the Department of Health Care and Finance to submit a report to the Council on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit for both fee-for-service and managed care organizations including any potentially applicable waiver authorities, and the amount of costs that would need to be allocated to federal and local funds for such coverage; to specify that a health insurer may not impose additional costs, waiting periods, pre-existing condition exclusions, and other limitations on coverage; to require health insurers to notify all policyholders and all prospective group policyholders with whom they are negotiating of the availability of coverage provided under this section; to define "ASRM", "infertility", "treatment for infertility", and "standard fertility preservation services"; and to require the Mayor to issue rules to implement the provisions of this section.

VIII. FISCAL IMPACT STATEMENT

The attached May 30, 2023, fiscal impact statement from the District's Chief Financial Officer states that funds are not sufficient in the fiscal year 2023 budget and proposed fiscal year 2024 through fiscal year 2027 budget and financial plan to implement the bill. The total cost of the bill is $1.69 million in fiscal year 2024 and $13 million over the financial plan. There are no costs in fiscal year 2023.

The Fiscal Year 2024 Local Budget Act, which passed on second reading on May 30, 2023, includes $1.69 million ($750,000 local; $940,000 federal) and $3.05 million ($1.36 million local; $1.67 million federal) over the financial plan to implement Medicaid and D.C. Healthcare Alliance coverage of infertility diagnosis and medically necessary ovulation enhancing drugs as

well as to pay the Department of Insurance, Securities and Banking's (DISB) costs under the bill. However, additional funding is needed at the Health Benefit Exchange Authority to implement infertility diagnosis and treatment coverage mandates for private health insurance providers.

IX. RACIAL EQUITY IMPACT

The Committee adopts the Racial Equity Impact Assessment provided by the Council's Office of Racial Equity, which is attached. The assessment finds that this Bill will likely improve access to infertility treatments for Black, Indigenous, Latine, and other residents of color who have health insurance but will not remove all barriers to accessing fertility treatments. The assessment further finds that the bill will maintain the status quo of access and affordability to infertility treatments for residents without health insurance.

Committee Response

The Committee appreciates the racial equity impact assessment and agrees that this bill will likely improve access to infertility treatments for many insured District residents of color.

X. SECTION-BY-SECTION ANALYSIS

Sec. 1 States the short title of the Bill.

Sec. 2 Amends the Women's Health and Cancer Rights Federal Law Conformity Act of 2000 to require an individual or group plan to provide coverage for the diagnosis and treatment of infertility and standard fertility preservation services; to require a health insurer offering health insurance coverage through Medicaid and the D.C. Healthcare Alliance program to cover the diagnosis and medication treatment of infertility; to require the Department of Health Care and Finance to submit a report to the Council on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit for both fee-for-service and managed care organizations including any potentially applicable waiver authorities, and the amount of costs that would need to be allocated to federal and local funds for such coverage; to specify that a health insurer may not impose additional costs, waiting periods, pre- existing condition exclusions, and other limitations on coverage; to require health insurers to notify all policyholders and all prospective group policyholders with whom they are negotiating of the availability of coverage provided under this section; to define "ASRM", "infertility", "treatment for

infertility", and "standard fertility preservation services"; and to require the Mayor to issue rules to implement the provisions of this section.

Sec. 3 Provides the fiscal impact statement.

Sec. 4 Provides the applicability.

Sec. 5 Provides the effective date.

XI. COMMITTEE ACTION

The Committee held a markup on May 31, 2023 to consider and vote on B25-34. The meeting was called to order at 1:00pm. Present and voting were Chairperson Christina Henderson and Councilmembers Nadeau, Parker, and Allen. Chairperson Henderson gave a description of B25-34 and expressed her gratitude for the public witnesses and District residents who reached out to share their experiences with infertility treatments before opening the floor for comments from the members.

Councilmember Nadeau commented that she had heard many stories during her years on the Council from constituents who needed infertility treatment services but encountered high costs and significant barriers to access. She noted that these cost barriers have created a system of inequity in which only individuals with sufficient financial resources can access needed infertility treatments. Councilmember Nadeau thanked Chairperson Henderson for her leadership moving this bill.

Councilmember Allen noted he had already voted to pass this bill in the Committee on Business and Economic Development earlier in the day. He highlighted two points. First, he noted that this bill would improve equity by reducing barriers of cost and access that currently make it such that only individuals of significant financial means can access infertility treatments. Second, he noted that this bill builds on work he undertook with the Committee on the Judiciary and Public Safety to reform surrogacy laws. He said the District continues to lead in the area of reproductive rights and ensuring all District residents are able to start a family.

Councilmember Parker expressed gratitude for the work of the Committee that will improve equity and access for individuals facing barriers to fertility services. He asked Chairperson Henderson about the distinction between coverage under private insurance and under Medicaid and the Alliance. Chairperson Henderson clarified the expansion of coverage for Medicaid and the Alliance, and she explained the need for DHCF to work with CMS to determine how to expand Medicaid coverage for infertility services to include IVF and standard fertility preservation services.

After discussion concluded, Chairperson Henderson moved for block approval of the Committee Report and Committee Print of B25-34 with leave for staff to make technical and

conforming changes. The Committee voted unanimously (4-0) to approve the Committee Print and the Committee Report with the members voting as follows:

YES: Henderson, Allen, Nadeau, Parker

NO: 0

The meeting went into recess at 1:16pm.

XII. ATTACHMENTS

(A) Bill 25-34, as introduced, and Referral Memo

(B) Notice of Public Hearing, as published in the *District of Columbia Register*

(C) Public Hearing Agenda, Witness List, and Witness Testimony

(D) Racial Equity Impact Assessment

(E) Fiscal Impact Statement

(F) Legal Sufficiency Determination

(G) Comparative Print of B25-34

(H) Committee Print of B25-34

ATTACHMENT
A

COUNCIL OF THE DISTRICT OF COLUMBIA
THE JOHN A. WILSON BUILDING
1350 PENNSYLVANIA AVENUE, NW
WASHINGTON, D.C. 20004

CHRISTINA HENDERSON
Councilmember, At-Large
Chairperson, Committee on Health

Committee Member
Hospital and Health Equity
Judiciary and Public Safety
Transportation and the Environment

Statement of Introduction
Expanding Access to Fertility Treatment Amendment Act of 2023
January 13, 2023

Today, I am proud to introduce the Expanding Access to Fertility Treatment Amendment Act of 2023, along with Councilmembers Kenyan McDuffie, Matthew Frumin, Robert C. White, Jr., Zachary Parker, Brianne K. Nadeau, Brooke Pinto, Janeese Lewis George, and Charles Allen. This legislation would expand coverage provided through private insurers, Medicaid and the DC Healthcare Alliance to include diagnosis and treatment for infertility.

About 11% of women of reproductive age and 9% of men in the United States have experienced fertility problems, delaying their ability to start families. And yet, the cost of diagnosis and treatment is inaccessible for many. The average in-vitro fertilization cycle can cost between $20,000 to $25,000. In the United States, 70% of women who undergo IVF go into debt to cover the cost, approximately 30,00 on average, which often causes treatment delays—34% of women stopped treatment because of unaffordability.

We know that women without insurance coverage are 3 times more likely to discontinue treatment after 1 cycle, compared to women with insurance coverage. To combat this unjust and inequitable access to one's human right, 20 states have passed fertility insurance coverage laws, including neighboring Maryland and West Virginia.

State mandated coverage has been shown to increase 3-fold the use of infertility services, which is also linked to better public health outcomes. Additionally, insurance coverage also reduces the likelihood of births of multiples to one mother, given that the financial pressure to transfer more than one to two embryos is reduced. This reduces the risk of complications and adverse health effects for the mother.

In addition to these risks faced by all mothers, Black and brown moms often wade through infertility silently and do not seek treatments like IVF as frequently as white mothers. Specifically, according to the CDC's most recent analysis[1], 8% of Black women age 25 to 44 seek medical help to get pregnant, while 15% of white women do so. As mentioned, state mandated coverage is proved to increase utilization of assisted reproductive technologies.

This bill would mandate private insurers, Medicaid, and the DC Healthcare Alliance to offer coverage for diagnosis and treatment of infertility. This legislation explicitly prohibits health insurers from:

[1] Center for Disease Control and Prevention, "Infertility Service Use in the United States: Data From the National Survey of Family Growth, 1982–2010" 2014. www.cdc.gov/nchs/data/nhsr/nhsr073.pdf

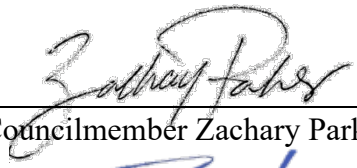
- Imposing additional costs, waiting periods, or other limitations on converge for the diagnosis of infertility;
- Placing pre-existing condition exclusions or waiting periods on coverage for the treatment of infertility, or using prior treatment for infertility as a basis for excluding, limiting or otherwise restricting coverage; and
- Limiting on coverage for fertility treatment based on a class protected under the Human Rights Act.

I am glad that this bill received a hearing during Council Period 24 when I first introduced it. Many people expressed their support for the bill and outlined the positive impact it would have for people trying to start a family.

I look forward to working with my colleagues to enhance coverage offered for future mothers and families in the District.

Councilmember Kenyan McDuffie

Councilmember Christina Henderson



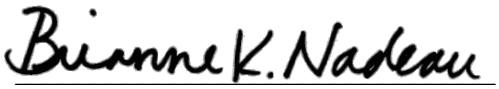
Councilmember Zachary Parker

Councilmember Janeese Lewis George

Councilmember Robert C. White, Jr.

Councilmember Charles Allen

Councilmember Matthew Frumin



Councilmember Brianne K. Nadeau

Councilmember Brooke Pinto

AN ACT

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Women's Health and Cancer Rights Federal Law Conformity Act of 2000 to require an individual health plan, group plan, or health insurer offering health insurance coverage through Medicaid and the D.C. Healthcare Alliance program to provide coverage for the diagnosis and treatment of infertility.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Expanding Access to Fertility Treatment Amendment Act of 2023".

Sec. 2. The Women's Health and Cancer Rights Federal Law Conformity Act of 2000, effective April 3, 2001 (D.C. Law 13-254; D.C. Official Code § 31-3831 *et seq.*) is amended to add a new section 5f to read as follows:

"Sec. 5f. Coverage of Fertility Treatments.

"(a)(1) Beginning January 1, 2025, an individual health plan, group health plan, health insurer, and a health insurer offering health insurance coverage through Medicaid and the D.C. Healthcare Alliance program shall provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization.

"(2) Every insurer shall communicate the availability of coverage to all policyholders and to all prospective group policyholders with whom they are negotiating.

"(b) Coverage for the treatment of infertility shall be provided without discrimination on the basis of age, ancestry, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

"(c) A health insurer shall not impose:

"(1) Deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for the diagnosis and treatment of infertility, including the prescription of fertility medications, different from those imposed upon benefits for services not related to infertility;

"(2) Pre-existing condition exclusions or pre-existing condition waiting periods on coverage for the diagnosis and treatment of infertility or use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting, or otherwise restricting the availability of coverage for required benefits; or

"(3) Limitations on coverage based solely on arbitrary factors including, but not limited to, number of attempts, dollar amounts, age, or provide different benefits to, or impose different requirements upon a class protected under the Human Rights Act of 1977, effective

December 13, 1977 (D.C. Law 2-38; D.C. Official Code § 2-1401.01 *et seq*.) than that provided to, or required of, other patients.

"(d) Nothing in this section shall be construed to interfere with the clinical judgment of a physician and surgeon.

"(e)(1) A health insurer offering health insurance coverage to an employer organized and operating as a nonprofit entity and referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, approved October 22, 1986 (100 Stat. 2740; 26 U.S.C. § 6033(a)(3)(A)(i) or (iii)) may issue a health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the employer's bona fide religious tenets.

"(2) Any health insurance policy issued pursuant to this subsection shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from the policy coverage.

"(f) For the purposes of this section, the term:

"(1) "Infertility" means the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

"(2) "Treatment for infertility" means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons, including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer."

Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal

impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 4. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

COUNCIL OF THE DISTRICT OF COLUMBIA
1350 Pennsylvania Avenue, N.W.
Washington D.C. 20004

Memorandum

To : Members of the Council

From : Nyasha Smith, Secretary to the Council

Date : Wednesday, January 18, 2023

Subject : Referral of Proposed Legislation

Notice is given that the attached proposed legislation was introduced in the Office of the Secretary on Friday, January 13, 2023. Copies are available in Room 10, the Legislative Services Division.

TITLE: "Expanding Access to Fertility Treatment Amendment Act of 2023", B25-0034

INTRODUCED BY: Councilmembers Henderson, Lewis George, Allen, Nadeau, McDuffie, Parker, R. White, Frumin, and Pinto

CO-SPONSORED BY: Councilmember Bonds

The Chairman is referring this legislation sequentially to the Committee on Business and Economic Development and the Committee on Health.

Attachment
cc: General Counsel
Budget Director
Legislative Services

ATTACHMENT
B

Council of the District of Columbia
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT
NOTICE OF PUBLIC HEARING
1350 Pennsylvania Avenue, N.W., Washington, D.C. 20004

COUNCILMEMBER KENYAN R. MCDUFFIE, CHAIRPERSON
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT

ANNOUNCES A
PUBLIC HEARING ON

B24-0228, THE "FAIR MEALS DELIVERY ACT OF 2021"

B24-0028, THE "HIV IN-HOME TEST TAX EXEMPTION AMENDMENT ACT OF 2021"

**B24-1033, THE "HILL EAST PHASE II BUNDLE 2 SURPLUS DECLARATION AND DISPOSITION APPROVAL ACT OF 2022"

B24-0829, THE "MEDICAL MALPRACTICE CLARIFICATION AMENDMENT ACT OF 2022"

B24-0831, THE "REPRODUCTIVE HEALTH CARE INSURANCE COVERAGE EXPANSION AMENDMENT ACT OF 2022"

B24-0699, THE "EXPANDING ACCESS TO FERTILITY TREATMENT AMENDMENT ACT OF 2022"

Tuesday, October 25, 2022, at 1:00 p.m.
Remote Hearing via Virtual Platform
Streamed live at https://www.kenyanmcduffieward5.com/live

On Tuesday, October 25, 2022, Councilmember Kenyan R. McDuffie, Chairperson of the Committee on Business and Economic Development, will hold a public hearing to consider the following measures:

- Bill 24-0228, the "Fair Meals Delivery Act of 2021"
- Bill 24-0028, the "HIV In-Home Test Tax Exemption Amendment Act of 2021" Amendment Act of 2022"
- Bill 24-1033, the "Hill East Phase II Bundle 2 Surplus Declaration and Disposition Approval Act of 2022"
- Bill 24-0829, the "Medical Malpractice Clarification Amendment Act of 2022"
- Bill 24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022"
- Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"

Bill 24-0228, the "Fair Meals Delivery Act of 2021" would require restaurants and third-party meal delivery platforms to enter into an express agreement that would authorize third-party meal delivery platforms to collect meal orders and deliver meals to customers as well as prohibit a third-party meal delivery platform from advertising or marketing contact information, image, or likeness of a restaurant on its platform.

Bill 24-0028 would exempt sales of HIV in-home tests from taxation in the District of Columbia.

Bill 24-1033 would declare District-owned real property at 1900 Massachusetts Avenue, SE as no longer required for public purposes. The measure would also approve its disposition for the creation of a mixed-use development consisting of 1,246 residential units (of which approximately 740 units would be reserved for below-market rate housing) and 60,000 square feet of retail space, among other amenities.

Bill 24-0829 would prohibit medical malpractice insurers from taking adverse action against a health professional who provides legal abortion care.

Bill 24-0831 would require private insurance companies to cover abortion care without imposing cost-sharing requirements.

Bill 24-0699 would expand coverage provided through private insurers, Medicaid, and the DC Healthcare Alliance to include diagnosis and treatment for infertility. The proposed measure would also prohibit health insurers from imposing additional costs or certain limitations on coverage and from placing pre-existing condition exclusions or waiting periods on coverage.

****Bill 24-1033 will be jointly heard with the Committee on Government Operations and Facilities, chaired by Councilmember Robert C. White, Jr.**

The Committee invites the public to testify remotely or to submit written testimony. Anyone wishing to testify must register in advance via the following link: https://dccouncil-us.zoom.us/webinar/register/WN_UWrZGAQOStO251PwFPSIsw **by 5PM Friday, October 21, 2022**.

Witnesses are encouraged to submit their written testimony in writing in advance of the roundtable to BusinessEconomicDevelopment@dccouncil.gov. To be included in the record, please indicate that you are submitting testimony for this hearing in the subject line of the e-mail. **The record for this hearing will close at 12PM Friday, October 28, 2022**.

Public witnesses will participate remotely and will receive a confirmation email after registering online as outlined above. All public witnesses will be allowed a maximum of three minutes to testify. At the discretion of the Chair, the length of time provided for oral testimony may be reduced or extended.

For accommodation requests, including spoken language or sign language interpretation, please BusinessEconomicDevelopment@dccouncil.gov of the need as soon as possible, but no later than five (5) business days before the proceeding. The Council will make every effort to fulfill

timely requests. However, requests received less than five (5) business days prior to the hearing may not be fulfilled and alternatives may be offered.

Please contact BusinessEconomicDevelopment@dccouncil.gov for additional information.

ATTACHMENT
C

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT
MEMORANDUM
1350 Pennsylvania Avenue, NW, Washington, DC 20004

TO:	Nyasha Smith, Secretary of the Council
FROM:	Kenyan McDuffie, Chairperson
RE:	Closing Hearing Record – B24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"
DATE:	December 1, 2022

Dear Secretary Smith,

Attached please find copies of the Agenda and Witness List and written testimony submitted for the Committee on Business and Economic Development's October 25, 2022, public hearing on Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022."

The following witnesses testified at the hearing or submitted written testimony to the Committee:

1. **Witness Testimony**
   - *i. Public Witnesses*
     1. Stephanie Oldano, Public Witness
     2. Sara Kloek, Public Witness
     3. Sarah Audelo, Public Witness
     4. Sara Imershein, MD MPH FACOG, Chair, DC Section of American College of Obstetricians and Gynecologists; Abortion Provider
     5. Trupti Patel, Commissioner, ANC 2A03
     6. Georgette Kerr, Volunteer, RESOLVE: National Infertility Association
     7. Julie Cangialosi, Founder, Operation Little Angel 101 Hope After Loss
     8. Katy, Bidwell, Public Witness
     9. Christa Kidd, Public Witness

        Maya Martin Cadogan, Public Witness
   - *ii. Government Witnesses*
     1. Phillip Barlow, Associate Commissioner, Department of Insurance, Securities, and Banking

Hearing Record
Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"

Table of Contents

Council of the District of Columbia
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT
NOTICE OF PUBLIC HEARING
1350 Pennsylvania Avenue, N.W., Washington, D.C. 20004

COUNCILMEMBER KENYAN R. MCDUFFIE, CHAIRPERSON
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT

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Please contact BusinessEconomicDevelopment@dccouncil.gov for additional information.

Council of the District of Columbia
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT
AGENDA AND WITNESS LIST
1350 Pennsylvania Avenue, N.W., Washington, D.C. 20004

COUNCILMEMBER KENYAN R. MCDUFFIE, CHAIRPERSON
COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT

ANNOUNCES A
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B24-0028, THE "HIV IN-HOME TEST TAX EXEMPTION AMENDMENT ACT OF 2021"

B24-0288, THE "FAIR MEALS DELIVERY ACT OF 2021"

Tuesday, October 25 2022, at 1:00 pm
Remote Hearing via Virtual Platform
Streamed live at https://www.kenyanmcduffieward5.com/live

AGENDA AND WITNESS LIST

I. CALL TO ORDER

II. OPENING REMARKS

III. WITNESS TESTIMONY

A. B24-1033, the "Hill East Phase II Bundle 2 Surplus Declaration and Disposition Approval Act of 2022"

i. Public Witnesses

1. Zulekha Inayat, Director of Development, BRP
2. Evens Charles, Managing Principal, Frontier Development & Hospitality Group
3. Kamau Brown, Head of Sales, Google
4. Babatunde Oloyede, President & CEO, Marshall Heights Community Development Organization, Inc.
5. Joel Caston, Commissioner, ANC 7F07
6. Tyrell Holcomb, Commissioner, ANC 7F01

ii. Government Witness

1. Daryl Thomas, Office of Deputy Mayor for Planning and Economic Development

B. B24-0829, the "Medical Malpractice Clarification Amendment Act of 2022"

i. Public Witnesses

1. Sara Imershein, MD MPH FACOG, Chair, DC Section of American College of Obstetricians and Gynecologists; Abortion Provider
2. Veronica Faison, Women's Law and Public Policy Fellow, National Women's Law Center

ii. Government Witness

1. Phillip Barlow, Associate Commissioner, Department of Insurance, Securities, and Banking

C. B24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022"

i. Public Witnesses

1. Sara Imershein, MD MPH FACOG, Chair, DC Section of American College of Obstetricians and Gynecologists; Abortion Provider
2. Serina Floyd, MD, MSPH, FACOG, VP of Medical Affiars & Medical Director, Planned Parenthood of Metropolitan Washington DC
3. Kay Hendrickson, Founder, Military Family Building Coalition
4. Lisa Rosenthal, Patient Advocate, Illume Fertility

ii. Government Witnesses

1. Phillip Barlow, Associate Commissioner, Department of Insurance, Securities, and Banking
2. Mila Kofman, Executive Director, DC Health Benefit Exchange Authority

D. B24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"

i. Public Witnesses

1. Stephanie Oldano, Public Witness
2. Sara Kloek, Public Witness
3. Sarah Audelo, Public Witness
4. Sara Imershein, MD MPH FACOG, Chair, DC Section of American College of Obstetricians and Gynecologists; Abortion Provider
5. Trupti Patel, Commissioner, ANC 2A03
6. Georgette Kerr, Volunteer, RESOLVE: National Infertility Association
7. Julie Cangialosi, Founder, Operation Little Angel 101 Hope After Loss
8. Katy, Bidwell, Public Witness
9. Christa Kidd, Public Witness
10. Maya Martin Cadogan, Public Witness

ii. Government Witness

1. Phillip Barlow, Associate Commissioner, Department of Insurance, Securities, and Banking

E. B24-0028, the "HIV In-home Test Tax Exemption Amendment Act of 2021"

i. Public Witnesses

1. Nirmal Maitra, Medical Student; Co-founder, Heroes for Hearts, Inc.

ii. Government Witness

1. Andrew Reiter, Assistant General Counsel, Office of Tax and Revenue

F. B24-0228, the "Fair Meals Delivery Act of 2021"

i. Public Witnesses

1. Che Ruddell-Tabisola, Director of Government Affairs and Member Advocacy, RAMW
2. Kathryn Wells, Posdoctoral Fritz Fellow, Georgetown University
3. Isabella Stratta, Public Witness
4. Neil Pareddy, Beeck Center for Social Impact and Innovation
5. Chris Svetlik, Owner, Republic Cantina

ii. Government Witness

1. Shirley Kwan-Hui, Interim Director, Department of Licensing and Consumer Protection

IV. ADJOURNMENT

Written Statement by Roy Ramthun
President, HSA Consulting Services, LLC
Silver Spring, MD 20901

for the

Committee on Business & Economic Development
Council of the District of Columbia

On Tuesday, October 25, 2022

concerning

Bill B24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022"

and

Bill B24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"

Dear Chairperson McDuffie, Councilmembers Allen, Cheh, Gray and Pinto and Committee Director DiFazio and staff, I submit this written statement for the October 25, 2022 hearing regarding two of the bills on the hearing agenda, specifically Bill B24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022," and Bill B24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022."

My name is Roy Ramthun. I am a consultant residing in nearby Silver Spring, Maryland, and I am a subject matter expert on Health Savings Accounts, having led the implementation of the HSA program after its enactment in 2003 while serving at the U.S. Treasury Department. I am submitting this Statement on behalf of the American Bankers Association (ABA) Health Savings Account Council, headquartered in the District of Columbia.

The HSA Council understands that abortion and abortion services are an important but controversial topic and we do not wish to insert ourselves in that debate. However, we feel an obligation to point out to the Committee the unintended consequences that could result if the bill is enacted in its current form.

Bill B24-0831 would require individual and group health plans sold in the District of Columbia to cover abortions and related services (including follow-up services) without any cost-sharing. This requirement would conflict with federal Internal Revenue Service (IRS) rules for High

Deductible Health Plans paired with Health Savings Accounts ("HSA-qualified plans"). Under IRS rules, HSA-qualified plans must apply a minimum deductible to all covered benefits received from in-network providers. The only exceptions are for "preventive care" services. While a broad range of contraceptive services are recognized as "preventive care" under the Affordable Care Act and IRS guidance, abortions and related services are not recognized as "preventive care" under either law.

Although this bill is intended to protect consumers from the cost of abortions and related services, the bill creates unintended consequences for consumers and their employers that use Health Savings Accounts with their HSA-qualified plans. A recent study conducted by the ABA revealed there are over 150,000 HSA account owners in the District of Columbia who could be adversely affected by this legislation.

As noted below, a solution would entail the bill being amended to provide an exception for High Deductible Health Plans paired with Health Savings Accounts so that they can comply with IRS rules. It would be most unfortunate to harm one group of consumers while attempting to help others.

In contrast, Bill 24-0669 (the "Expanding Access to Fertility Treatment Amendment Act of 2022") does not raise similar concerns because it would only require health insurers to cover the diagnosis and treatment of infertility (including in vitro fertilization) with cost-sharing that is no different than cost-sharing for services not related to infertility. We interpret the bill's language to mean that health insurers are not required to cover these services without cost-sharing and may apply deductibles and other cost-sharing to the cost of diagnosis and treatment of infertility. That is important for HSA-qualified plans because the IRS does not consider the diagnosis and treatment of infertility to be "preventive care" services.

Below, I provide additional information and explain these issues and concerns in more detail.

What are Health Savings Accounts?

Health Savings Accounts (HSAs) are trust or custodial bank accounts similar to Individual Retirement Accounts (IRAs). Adults may contribute to an HSA only if they are enrolled in an "HSA-qualified" high deductible health plan and do not have other coverage that disqualifies them, such as Medicare, Medicaid, and private coverage that does not meet the requirements outlined below. HSAs are designed to help individuals and families plan for and manage their out-of-pocket expenses.

Contributions to HSAs are tax-deductible from income and are "pre-tax" when made by an employer or by employees via payroll deduction. Contribution limits are set by federal statute. For 2022, the contribution limits are $3,650 for single individuals and $7,300 for families. Individuals aged 55 or older may also make annual "catch-up" contributions of $1,000.

HSA funds may be used tax-free for IRS-approved health care and related expenses, including deductibles, copayments, and other out-of-pocket expenses. There is no "use it or lose it" rule

for HSA funds. Unused HSA funds may be saved for future use and/or invested like an IRA. Like IRAs, HSAs are completely portable.

What are "HSA-Qualified" Plans?

Under federal statute (Sec. 223 of the Internal Revenue Code) and implementing guidance from the federal Internal Revenue Service, "HSA-qualified plans" must meet specific requirements, including applying:

1. A minimum annual deductible to all covered benefits (medical plus pharmacy) received from in-network health care providers. For 2022, the minimum annual deductible is $1,400 for individuals with self-only coverage and $2,800 for individuals with family coverage. These amounts are adjusted annually for inflation and may change from year to year. Plan deductibles cannot exceed the annual limits on out-of-pocket expenses described below.

   Exceptions:

   A. "Preventive care" services are exempt from the minimum deductible requirement if the services are either (1) required under the Affordable Care Act, or (2) recognized as "preventive care" and permitted under IRS guidance for HSA-qualified plans.
   B. HSA-qualified plans may apply higher deductibles to covered benefits received from out-of-network health care providers.

2. An annual limit on out-of-pocket expenses that includes all cost-sharing for covered benefits received from in-network providers. For 2022, the annual limit on out-pocket expenses cannot exceed $7,050 for individuals with self-only coverage and $14,100 for individuals with family coverage. These amounts are adjusted annually for inflation and may change from year to year. Note that these limits are substantially lower than the annual out-of-pocket limits required under the Affordable Care Act ($8,700 for individuals with self-only coverage and $17,400 for individuals with family coverage for 2022).

What are "preventive care" services as defined by the IRS?

Section 223(c)(2)(C) provides a safe harbor for coverage of "preventive care" below the minimum policy deductible. Thus, HSA-qualified plans may provide preventive care benefits without a deductible, or with a deductible below the minimum annual deductible. In Notice 2004-23, the IRS defined "preventive care" to include, but not limited to, the following:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
- Routine prenatal and well-childcare
- Screening services for diseases (such as cancer, heart disease, infectious diseases, mental health conditions, etc.)

- Child and adult immunizations
- Tobacco cessation programs
- Obesity weight-loss programs

However, the Notice also states that preventive care "does not generally include any service or benefit intended to treat an existing illness, injury, or condition." Section 223(c)(2)(C), for purposes of an HSA, does not condition the exception for preventive care on State law requirements. State insurance laws often require health plans to provide certain health care without regard to a deductible or on terms no less favorable than other care provided by the health plan. The determination of whether health care that is required by State law to be provided by an HDHP without regard to a deductible is "preventive" for purposes of the exception for preventive care under section 223(c)(2)(C) is based on the standards set forth Notice 2004-23 and other guidance issued by the IRS, rather than on how that care is characterized by State law, or in this case, District law.

In July, 2004, the IRS issued Notice 2004-50 which further clarified the definition of "preventive care" and incorporated comments received, as requested by the prior notices. This notice clarified that "preventive care" includes:

1. A preventive care service or screening that also includes the treatment of a related condition during that procedure, in situations where "it would be unreasonable or impracticable to perform another procedure to treat the condition, any treatment that is incidental or ancillary to a preventive care service or screening as described in Notice 2004-23." The notice gave the example of the removal of polyps during a diagnostic colonoscopy.
2. Drugs or medications "when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered." The notice gave two examples:
    a. Treatment of high cholesterol with cholesterol-lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence; and,
    b. Drugs or medications used as part of procedures providing preventive care services specified in Notice 2004-23, including obesity weight loss and tobacco cessation programs.

However, Notice 2004-50 re-iterated previous IRS guidance stating that the preventive care safe harbor under section 223(c)(2)(C) does not include any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications used to treat such an existing illness, injury or condition.

In 2010, the Affordable Care Act embraced the concept of first-dollar coverage of preventive care services and created a new list of preventive care services that all health insurance coverage (except for "grandfathered" plans) must cover without cost-sharing. These requirements include:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration (HRSA).
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the HRSA for purposes of this paragraph.
5. for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

The requirements can be found in Sec. 2713 of the Public Health Service Act.

A few years later, the IRS issued Notice 2013-57 which clarified that a health plan will not fail to qualify as an HSA-qualified plan under section 223(c)(2) of the Internal Revenue Code merely because it covers the preventive health services required under section 2713 of the Public Health Service Act without any cost-sharing.

After several states (most notably Maryland) passed laws in 2016 and 2017 requiring health insurers to cover male vasectomies without cost-sharing, the IRS issued Notice 2018-12 which clarified that a health plan providing benefits for male sterilization or male contraceptives without a deductible, or with a deductible below the minimum deductible for an HSA-qualified plan under section 223(c)(2)(A) of the Internal Revenue Code, is not an HSA-qualified plan.

In 2019, the IRS published Notice 2019-45 which, for the first time, recognized specific services provided to individuals with certain chronic conditions as "preventive care" that may be covered by HSA-qualified plans without a deductible or other cost-sharing. The list of services and conditions is limited to those found in the table below.

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

NOTE: The "Inflation Reduction Act of 2022" (P.L. 117-169) included a provision (Sec. 11408) codifying the "safe harbor" for insulin in the HSA statute. This provision will allow health insurers offering HSA-qualified plans to cover insulin for any individual (not just diabetics) without applying a deductible or other cost-sharing.

Finally, after the beginning of the COVID-19 pandemic, the IRS issued Notice 2020-15 stating that HSA-qualified plans could cover vaccinations, testing and treatment for COVID-19 without applying a deductible or other cost-sharing.

Why are state benefit mandates generally problematic for HSAs?

State-level health insurance mandates, although well-intended, can conflict with federal requirements for HSA-qualified plans which creates an unintended impact on consumers' ability to contribute to their HSAs. This happens when benefit mandates require coverage without deductibles and/or with limited cost-sharing for treatments or services for particular diseases or conditions that are not considered "preventive care" under either the Affordable Care Act or IRS guidance.

Other Jurisdictions and Steps Taken Nationally to Educate and Advocate

The District is not alone in these challenges. Due to the input of my colleagues and I, and that of Chambers of Commerce, state bankers associations, and health insurance plans, many states' legislators and insurance regulators have only recently learned about the impact of these proposals. The HSA Council has offered amendments to provide an exception for HSA-qualified plans, and we have been successful in procuring amendments to bills considered in many (although not all) jurisdictions. We are hopeful that your Committee will adopt a similar amendment to preserve District consumers' ability to continue participate in HSAs.

In an attempt to address this issue via a top-down approach, the HSA Council continues to discuss these issues with state legislators and regulators, and various national organizations, including the National Council of Insurance Legislators (NCOIL), the National Conference of State Legislatures (NCSL), the NAIC, and the Council of State Governments (CSG), among others. Earlier this year, I testified before the NAIC's (Health Insurance) Regulatory Framework Task Force on these issues. I would be pleased to share my testimony with the Committee.

What is the Immediate Solution?

We recommend that the bill be amended to include an exception for HSAs, so that HSA owners may continue to fund their accounts to pay for qualified medical expenses. We would be pleased to offer suggested language or review language being considered by the Committee.

A Roadmap to a Future, Broader Solution

We also request that the Committee and the City Council consider a broader approach in the future, similar to laws in Arkansas, Oregon, Rhode Island and Utah, that embed an exception for HSAs in the District's insurance code to protect against the adverse effect of any and all similar future legislation. This would also provide "legislative economy" in that it would eliminate the necessity to amend each and every future bill that comes before this Committee, the Health Committee, and the Council.

Conclusion

In conclusion, we respectfully request that the Committee amend B24-0831 to provide an exemption for HSA-qualified plans.

Thank you for the opportunity to provide this statement.

Respectfully Submitted on Behalf of the American Bankers Association Health Savings Account Council,

Roy Ramthun

cc.: Mr. J. Kevin McKechnie, Founder and Senior Vice President, American Bankers Association Health Savings Account Council-Washington, D.C.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

District of Columbia Section

Testimony for the Committee on Business & Economic Development Hearing
B24-699 Expanding Access to Fertility Treatment Amendment Act of 2022

Thank you Chairman McDuffie, and members of the Committee on Business and Economic Development. Thank you for the intent of this important legislation.

My name is Dr Sara Imershein. I am a board-certified obstetrician-gynecologist and Clinical Professor at George Washington University. I have lived and practiced medicine in the District of Columbia since 1984. I am Chair of the DC Section of the American College of Obstetricians and Gynecologists (ACOG). ACOG, with over 58,000 members, maintains the highest standards of clinical practice and continuing education for our members – your DC doctors. We endorse and support **B24-699** *Expanding Access to Fertility Treatment Amendment Act of 2022* … only with several important modifications.

We applaud the intent of this legislation - to create equity with private and publicly – funded health insurance – parity between privileged and marginalized patients.
I am not a lawyer, but to me the legislation, as written, is simultaneously vague and too narrow – frozen in time. Currently, I am unaware of any insurance plan that pays for unlimited fertility treatments. IVF cycles, for example are often limited because the huge on-going expense is not justified by exponentially diminishing returns with each failed cycle of fertility treatment. Age limits or limits on patients with absent or totally non-functioning reproductive organs, for example would preclude futile expenditures. The bill does not address egg retrieval (or sperm collection) and storage for future use. The bill does not address surrogacy, a 'treatment' for many types of infertility – including a 'fertility' solution for same-sex couples. It does not address donor egg or donor sperm. And it defines infertility after one year, although fertility specialists encourage females over 35 years-old to seek evaluation and treatment after six-months, because time is essential to optimize diminishing age-associated fertility. Indeed, defining infertility beginning at 12-months discriminates against older females. And there are multiple reasons more white women seek infertility treatment than access alone. White and Asian women delay first childbirth (voluntarily or because of infertility) an average of 3-5 years later than non-Hispanic Black women. Expanding access and coverage is good, but not unlimited access.

If the bill did name all the afore-mentioned procedures it would still be inadequate. Medicine evolves. Next year, or the year, or the year after that … sometime in the future there will be newer/better/safer procedures denied to patients because the definitive list in this bill excluded technology in development …because we can't predict future scientific successes under investigation or not yet imagined … or might require new legislation or litigation to get better treatments covered.

Indeed, as written **B24-699** an open check-book for futile infertility workups, and ripe for abuse.
But don't throw the baby out with the bathwater. Please keep the intent. Work with fertility specialists. Consider reasonable treatments and reasonable limits. With our limited healthcare dollars we can't allow unlimited infertility evaluation or treatment to out-spend …cancer! or kidney dialysis! or Cardiac surgery! Or outspend its utility.

We at ACOG are available for consultation anytime legislation is being written, even before bills are submitted. We can provide our professional insight on legislation that impact our constituents – reproductive healthcare providers, our patients and their families. Thank you for considering public comment on **B24-699** *Expanding Access to Fertility Treatment Amendment Act of 2022.* It's a good start and a great goal, but not ready to be passed and enacted as written.

Respectfully submitted,

Sara Imershein, MD MPH FACOG

Fellow, Senior Status and Chair
District of Columbia Section,
American College of Obstetricians and Gynecologists

Pamela Lotke, MD MPH FACOG
Fellow, Executive Committee, District of Columbia Section,
American College of Obstetricians and Gynecologists

October 25, 2022

D.C. CATHOLIC CONFERENCE

ADVANCING GOSPEL VALUES IN THE DISTRICT OF COLUMBIA

Committee on Business and Economic Development
Public Hearing on October 25, 2022

B24-699, Expanding Access to Fertility Treatment Amendment Act of 2022

Struggling with infertility can be a great burden for couples who desire to have children and they are deserving of support. Children are a great good, and therapeutic treatments to overcome obstacles to conception and birth are legitimate and praiseworthy when they serve the integral good of all. The D.C. Catholic Conference therefore supports expanded access to *appropriate* infertility treatment and believes that this care should be accessible for all persons.

Assisted reproductive technologies like *in vitro* fertilization, on the other hand, *per se* contradict the dignity of the human person and are not without risk of medical complications to the woman who undergoes the procedures. For these reasons, despite its salutatory purpose, we cannot support B24-699, Expanding Access to Fertility Treatment Amendment Act of 2022, although we are thankful for the inclusion of a necessary religious exemption in the bill.

We recognize the challenges and unseen pain caused by infertility and the Roman Catholic Archdiocese of Washington has ministries to help families. The Catholic Church also continues to support natural procreative technology that provides holistic gynecological approaches to medicine and surgery, which have proven to be extremely effective. We support as well increased tax credits that offset the cost of adoption services in the District. We hope that the Council will help couples experiencing infertility by promoting safe and affordable healthcare that affirms the dignity of both parents and children.

October 24, 2022

Chairperson Kenyan R. McDuffie
Council of the District of Columbia
Committee on Business and Economic Development
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

RE: B24-0699 The Expanding Access to Fertility Treatment Act Amendment of 2022

Dear Chairperson McDuffie and Members of the Committee:

On behalf of the Alliance for Fertility Preservation, we are writing to express our views on B24-0699, *The Expanding Access to Fertility Treatment Act Amendment of 2022*. We are a national 501(c)(3) organization dedicated to expanding fertility preservation information and resources for patients facing potential infertility caused by cancer treatments. While we support the in vitro fertilization (IVF) coverage provisions in B24-0699, we also believe the legislation should include coverage for patients who need to preserve their fertility out of medical necessity.

Approximately 2,085 residents of the District of Columbia between the ages of 0-39 are diagnosed with cancer each year. Due to improvements in treatment, about 85% these patients will survive. Some cancer treatments, however, can cause iatrogenic infertility when chemotherapy, radiation, and surgery damage reproductive cells (eggs and sperm), reproductive organs, and/or endocrine functioning; they can also adversely impact the ability to carry a pregnancy. Since cancer patients facing potentially sterilizing treatment fall outside of the definition of "infertility," B24-0699 would not address these situations.

Fertility preservation has been considered part of the standard of care for age-eligible cancer patients for more than fifteen years, and is recognized by all the relevant medical associations, including the American Society of Clinical Oncology (ASCO), the American Society for Reproductive Medicine (ASRM), and the American Medical Association (AMA). Currently, sperm, egg, embryo, and ovarian tissue banking are viewed as standard fertility preservation procedures.

Over the last five years, 12 states implemented some coverage for medically-necessary fertility preservation – Connecticut, Rhode Island, Maryland, Delaware, Illinois, New York, New Hampshire, California, New Jersey, Colorado, Utah, and Maine. At the federal level, the U.S. Veterans' Health Administration, TRICARE and the Federal Employees Health Benefit (FEHB) Program have recently recognized this coverage as well.

Our Board of Directors and Medical Advisors are professionals with deep experience and commitment to this issue, most in the clinical setting. We have seen first-hand the profound sense of unfairness and loss that these patients and their families have upon understanding that the cost of surviving their cancer might be the loss of parenthood. We strongly believe

that having cancer should not preclude having children, especially when there are standard medical interventions available to prevent this loss.

We applaud your consideration of this legislation and respectfully ask that B24-0699 include coverage for patients who need to preserve their fertility out of medical necessity.

Sincerely,

Joyce Reinecke
Executive Director

Georgette Kerr, Volunteer, RESOLVE: The National Infertility Association
Testimony for DC Council
Committee on Business and Economic Development
Hearing on Bill 24-0699, the Expanding Access to Fertility Treatment Amendment Act of 2022
October 25, 2022

Chairperson McDuffie, Co-Chair White, Councilmember Henderson, and members of the committee, thank you for the opportunity to testify today in support of Bill 24-0699, the Expanding Access to Fertility Treatment Amendment Act of 2022.

My name is Georgette Kerr and I have been a DC resident since 2006. For the past three years, I have been a volunteer and the DC state captain for RESOLVE: The National Infertility Association. Earlier this year, I worked with Mayor Muriel Bowser's office on a proclamation declaring April 24-30 National Infertility Awareness Week in the District of Columbia to raise awareness about infertility and barriers faced by the family building community in the district. With the legislation being considered today, the DC Government now has an opportunity to move beyond raising awareness and to increasing access to care for district residents.

I am 1 in 5 people living in Washington, DC who struggle with infertility. I am 1 in 4 women who has experienced a miscarriage. This is because my husband is 1 in 800 people who suffer from a rare genetic condition known as a balanced chromosome translocation. If we tried to conceive naturally, at best, we would have 1 in 8 odds of bringing home a healthy baby. Often, couples with this diagnosis experience double digit miscarriages, and the physical and emotional trauma to accompany them, in their efforts to build their families. For couples like us, this makes IVF, which allows for analysis of an embryo's chromosomes, the best shot for safely conceiving a healthy baby.

We always envisioned our family with two children, and having biological children remains a priority and an important part of our identity as a couple. When we decided that IVF was the right path for us, we quickly learned we had no access to health insurance that would provide even partial coverage for fertility treatment. I am the part-owner of a small business founded here in Washington, DC. All our employees secure their health ensure through a spouse or DC Health Link, which has never offered plans with fertility benefits. My husband is a Marine Corp veteran who is now a civilian civil servant for the Air Force. Strict eligibility criteria meant that the VA offered us no support. Further, the Federal Employee Health Benefits Plan (FEHBP) has traditionally not offered plans with fertility benefits. The federal Office of Personnel Management (OPM) will just begin offering four new plans with very limited assisted reproductive technology benefits next year.

Only because we were fortunate enough to have the means to pay out of pocket for fertility treatment, I am now an IVF mom. My rainbow baby turns one on Thursday. It took us two egg retrievals and two frozen embryo transfer cycles to bring my daughter home. She has brought such joy into our lives that earlier this year, we pursued IVF again to try to make her a sibling. While we are still in the process of completing our family, to date, our testing, treatments, and

medication have cost us roughly $70,000 out of pocket, an investment that is unfathomable for many families in the district, especially in today's economic environment.

There are so many amazing would-be parents who, on top of the physical discomfort and emotional anxiety of going through fertility treatment, quickly burn through their savings or clean out their retirement accounts for just the chance to become pregnant with the support of assisted reproductive technology. No one should have to go through the grueling journey of treatment for infertility with the added pressure of trying to figure out how to make it affordable while still making ends meet. Infertility is a disease, and just like any other disease, it should be covered.

I am grateful that my journey with infertility is coming to an end. However, being empowered with the knowledge from IVF that my children have inherited their father's genetic condition, my husband and I have made it a personal mission to advocate for policy change to ensure they encounter fewer barriers to family building than we did. Having spent the past three years of my life consumed by infertility, I am also proud to stand with all the brave men and women in DC who have lacked access to treatment for infertility for far too long.

That said, I urge this committee and the committee and the full DC Council to expeditiously pass the Expanding Access to Fertility Treatment Amendment Act of 2022 so that our great city can join the 19 other states that have already mandated fertility coverage. Thank you for your consideration. Please consider me a resource as the Council considers additional ways it might support DC residents struggling with infertility.

Nation's Capital Chapter

P.O. Box 29154 ▪ Washington, DC 20017

October 28, 2022

Chairperson Kenyan R. McDuffie and Members of the Committee on Business and Economic Development,

The Nation's Capital Chapter of Jack and Jill of America, Inc. ("Chapter") is pleased to submit testimony in favor of Bill 24-0699, *Expanding Access to Fertility Treatment Amendment Act of 2022* ("Bill"). Jack and Jill of America, Inc. is a nonprofit organization of members who are mothers with children between the ages of two and nineteen. Founded in 1938, this national organization is dedicated to improving the quality of life for children, with a focus on those that identify as African American.

The Chapter's mission is to provide enriching opportunities for children to develop skills and passions that prepare them to be leaders of the next generation. We are especially dedicated to ensuring that all children, not just our own, have these opportunities. Activities are designed to focus on serving the community and reflect core themes our children are exposed to as residents of the District of Columbia: leadership, political engagement, and advocacy.

As we understand it, this Bill "would expand coverage provided through private insurers, Medicaid, and the DC Healthcare Alliance to include diagnosis and treatment for infertility. The proposed measure would also prohibit health insurers from imposing additional costs or certain limitations on coverage and from placing pre-existing condition exclusions or waiting periods on coverage." (Hearing Notice on Bill 24-0699, *Expanding Access to Fertility Treatment Amendment Act of 2022* Before the Committee on Business and Economic Development, Council of the District of Columbia).

We find this measure extraordinarily important to expand access to fertility treatment to District residents, particularly Black people and families. Our considerations are as follows:

1. When financial barriers are removed or reduced, there is an increase in use of fertility treatment by Black people.[1]

2. Increased access to fertility treatment may also address the shame of infertility for Black people and other people of color.[2]

3. Our Chapter mothers have benefited from access to fertility treatments and would like other people – specifically people of color – to benefit from these transformational treatments.

4. While this is an excellent first step, that will permit Black people and families to grow their families, we also believe that the Council of the District of Columbia ("Council") should continue to research ways to ensure that

[1] American Psychological Association, *Infertility and BIPOC (Black, Indigenous & People of Color) Women*, https://www.apa.org/pi/women/committee/infertility-bipoc (last visited Oct. 27, 2022).
[2] *Id.*

fertility services are not fraught with challenges for Black people as other parenting and maternal healthcare services tend to be.[3]

Without question, financial barriers are one of the most daunting hurdles for Black families considering fertility treatment use. Per a recent article in *Parents* magazine "[i]Infertility is pronounced in communities of color … [and] African-American women experience infertility at rates similar to and higher than White counterparts. The desire to parent does not have a color line… if assisted reproductive technologies are outside of reach, because of economic constraints, then Black families may be less likely to have meaningful access."[4] The fact that fertility treatment is cost-prohibitive is not just an unfortunate "access issue". The same article notes that "[t]he American Society for Reproductive Medicine (ASRM) declared the lack of access to fertility treatment in the United States a reproductive justice issue." [5]It is our sincere hope that this bill can address some of the financial hurdles that ultimately restrict access to fertility treatment for Black people families, and other people of color.

We also note that financial reasons, while likely one of the larger barriers to fertility treatment, are not the only barrier to fertility treatment for Black people and families. Barriers for BIPOC can include cultural and psychological reasons. Some people can associate their infertility with failing as a woman, wife or partner because that is the prevailing view in their culture. A published article by the American Psychology Association noted that "[m]any women who experience infertility may relate to their feelings of shame at not being able to conceive…." [6] However, our Chapter maintains that this Bill may help to address shame. If people can more readily use insurance to pay for fertility treatment, therefore increasing the opportunity to use treatment, this may relieve some of the shame associated with infertility since they will have access to resources they need to increase their chances to conceive.

Some of our Chapter member mothers have used the science of fertility treatment to expand their families, and this bill would give more families an opportunity to share in this joy. Oftentimes, Chapter members are pleasantly surprised to find that fellow Chapter members have used fertility treatment to conceive. Ultimately, members are happy to have a community of women who understand how life-changing treatment can be. After hearing of this Bill's introduction, many mother members were eager for the Chapter to submit testimony supporting this Bill because they value the community they have and the opportunity afforded to them. This bill would remove unnecessary impediments to fertility treatment and give families an opportunity to share in the joy of parenthood.

After passage of this critically important legislation, the Council should continue to review how to address the problematic state of the fertility industry for BIPOC. While we are deeply pleased to know people who have successfully utilized fertility treatment, we understand that comprehensive research on the state of fertility services for Black people is necessary. More specifically, "[r]esearchers found that Black women who undergo fertility treatment have markedly worse outcomes than their white counterparts. We have a lower live birth rate for the initial cycle, independent of factors such as age, ovarian reserve, past miscarriages, or the number of embryos transferred."[7]

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[3] Jacquelynn Kerubo, "What Black Women Need to Know Before Seeking Fertility Treatment," Apr 11, 2021, *Self*, https://www.self.com/story/black-women-and-infertility.
[4] Fiona McKinson, I*VF is Cost-Prohibitive for Far Too Many Black & Brown Families—These Orgs Are Changing That*, Feb. 8 2022, Parents, https://www.parents.com/parenting/money/family-finances/starting-out/ivf-cost-prohibitive-black-brown-families/.
[5] *Id*.
[6] American Psychological Association, *Infertility and BIPOC (Black, Indigenous & People of Color) Women*, https://www.apa.org/pi/women/committee/infertility-bipoc (last visited Oct. 27, 2022).
[7] Jacquelynn Kerubo, "What Black Women Need to Know Before Seeking Fertility Treatment," Apr 11, 2021, *Self*, https://www.self.com/story/black-women-and-infertility.

Additionally, research shows that "[c]lose to half of Black women reported that their physician does not understand their cultural background when seeking fertility treatment".[8]
. Moreover, "[l]ow-income Latina women receiving care in a fertility clinic reported linguistic and cultural communication challenges with providers, as well as perceptions of providers being uncaring."[9] In 2014, the *New York Times* reported a "knowledge gap" that black women in particular have about infertility options.[10]
These points concern us deeply. We would support further review of this issue similar to that of the Maternal Mortality Review Committee or another investigatory reporting entity that can shed light on this area of healthcare.

Our Chapter is pleased to support this Bill and know that this Bill can address some of the financial and physiological reasons people, specifically Black people, do not seek fertility in the first place. Chapter members also want other District families to know the joy of parenthood that they experienced that was made possible by fertility treatment. After passage of this Bill, however, we encourage the Council to consider further investigation into the state of the fertility industry for BIPOC. Thank you for the opportunity to submit testimony on this important Bill and we are happy to discuss the bill further with the Committee on Business and Economic Development staff if necessary.

Respectfully,

BKN Mitchell

Barbara Mitchell, Esq.
Legislative Liaison
Nation's Capital Chapter
Jack and Jill of America, Inc.
818-970-6225
Barbara.kn.Mitchell@gmail.com.

[8] American Psychological Association, *Infertility and BIPOC (Black, Indigenous & People of Color) Women*, https://www.apa.org/pi/women/committee/infertility-bipoc (last visited Oct. 27, 2022).
[9] *Id*.
[10] Tanzina Vega, "Infertility, Endured Through a Prism of Race," *New York Times* https://www.nytimes.com/2014/04/26/us/infertility-endured-through-a-prism-of-race.html.

Olson, Morgen (Council)

From: Katy Bidwell <bidwell.katy@gmail.com>
Sent: Thursday, October 27, 2022 3:31 PM
To: Olson, Morgen (Council)
Subject: Re: Draft Agenda and Witness List for 10-25-22 CBED Hearing

Thank you for the information. I logged on at 2 as suggested but had to leave by 3:15pm so was not able to give testimony for B24-0699. I looked at the website but it was unclear to me how to submit written testimony so I am typing mine below and hope you can forward it to where it belongs. I think having better time allocation for each measure would benefit lay people who need to take time out of the work week to try and be present for the hearing... I was really looking forward to sharing my story and was frustrated that there was such vague time keeping.

I appreciate your service for DC constituents,
Katy Bidwell

When it was discovered that I had uterine fibroids and a thin lining (a common condition affecting the fertility of many women) it was emotionally difficult to process that I would need medication and professional assistance to build the family I had long hoped for. That process was made even more difficult when I learned the health care I needed to conceive was deemed 'elective' by my DC HealthLink insurance and that we would have to pay $2500 out of pocket for each cycle that we tried.

It was frustrating to learn that if we lived just miles away in Maryland then my care would have been recognized as the medically necessity it was. I personally know of couples who have moved out of DC for this reason, and it is a real loss to the District. We considered waiting until I could find a job that offered coverage (and I know many women who work at Starbucks for this reason alone). It feels unjust that affordable fertility care only be available to women who happen to live in the 'right' place or work at the 'right' job.

Since I am older I didn't have the luxury of waiting to treat my reproductive disease so we decided to take on the added financial burden in order to start our family. While my journey has a happy ending, it breaks my heart to think of all the DC families that do not exist today due to this gap in affordable health care. I applaud the efforts of this bill to correct the inequities that DC's women currently face and I hope it prevents others from experiencing the stress I did when needing treatment.
Thank you,
Katy Bidwell

On Mon, Oct 24, 2022 at 2:16 PM Olson, Morgen (Council) <molson@dccouncil.gov> wrote:

> Hi All,
>
> Please find the draft agenda/witness list for tomorrow's hearing attached. You will notice that the Committee will begin with the Hill East measure and conclude with the Fair Meals bill. That said, those testifying on the reproductive health care and fertility measures (B24-0831, B24-0829, and B24-0699) may wish to log in around 2PM; that is the Committee's best guess for when the measures will be heard.
>
> Best,

Morgen Olson, Esq.

Legislative Counsel

Councilmember Kenyan McDuffie, Ward 5

Chair Pro Tempore

Council of the District of Columbia

1350 Pennsylvania Ave., NW, Room 506

Washington, DC 20004

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Visit us on the web at http://www.kenyanmcduffieward5.com/

LEUKEMIA & LYMPHOMA SOCIETY®

Testimony of The Leukemia & Lymphoma Society
In favor of the inclusion of Fertility Preservation Language being added to B24-0699-Expanding Access to Fertility Treatment Amendment Act of 2022

October 28th, 2022

The Leukemia & Lymphoma Society (LLS) is pleased to submit the following testimony to the Committee on Business and Economic Development, in favor of adding fertility preservation language to B24-0699 "Expanding Access to Fertility Treatment Amendment Act of 2022".

At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients.

Many of those blood cancer patients are young adults. Blood cancers, including leukemia, non-Hodgkin's lymphoma, and Hodgkin lymphoma, are among the most common types of cancer diagnosed in children and young adults, and leukemia alone accounts for nearly a quarter of all cancers diagnosed in people under the age of 20.[1]

The good news is that advancements in research and treatment of these conditions have led to significant improvements in survival rates for pediatric cancer patients. However, fertility preservation is an essential consideration for pediatric and young adult blood cancer survivors. Blood cancers and their treatments, particularly cell transplants, carry a significant risk of infertility.[2] LLS views B24-0699 with the inclusion of fertility preservation language, as a medically responsible and compassionate proposal to help these survivors preserve their parenting options more fully.

Even with comprehensive insurance coverage, blood cancer patients can face significant treatment costs, particularly in the twelve months following diagnosis.[3] No patient, or parents of a young patient, should be put into a position where they have to weigh the additional costs of fertility preservation services that are only necessary because of their cancer treatment against the costs of the treatment itself.

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[1] "Childhood Blood Cancer Facts and Statistics." The Leukemia & Lymphoma Society. Available at: https://www.lls.org/facts-and-statistics/overview/childhood-blood-cancer-facts-and-statistics
[2] Loren, Alison W., and S. Senapati, "Fertility preservation in patients with hematologic malignancies and recipients of hematopoietic cell transplants." *Blood*, 2019. Available at: https://ashpublications.org/blood/article/134/9/746/260765/Fertility-preservation-in-patients-with.
[3] "The Cost Burden of Blood Cancer Care." Milliman Inc. for The Leukemia & Lymphoma Society. October 2018. Available at: https://www.lls.org/sites/default/files/Milliman%20study%20cost%20burden%20of%20blood%20cancer%20care.pdf

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LEUKEMIA & LYMPHOMA SOCIETY®

We urge the members of the Committee to add fertility preservation language to the bill and to pass B24-0699.

If you have questions about LLS's position on this matter or would like further information from LLS, please contact Ernie Davis at Ernie.Davis@LLS.org or 614-595-2836.

Ernie Davis
Regional Director of Government Affairs
The Leukemia and Lymphoma Society

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10 G Street NE
Suite 400
Washington, DC 20002
Main 202.408.7631
www.LLS.org

Olson, Morgen (Council)

From: Mary Laura Calhoun <mlcalhoun@gmail.com>
Sent: Monday, October 24, 2022 6:20 PM
To: Commmittee on Business and Economic Development
Subject: testimony for B24-0831, THE "REPRODUCTIVE HEALTH CARE INSURANCE COVERAGE EXPANSION AMENDMENT ACT OF 2022"

Dear Councilmember Kenyan R. McDuffie, Chairperson and the Committee on Business and Economic Development,

I am writing as DC employee and resident to express my support in favor of the Bill B24-0831, the Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022.

Infertility is surprisingly common. CDC statistics show that "among heterosexual women aged 15 to 49 years with no prior births, about 1 in 5 (19%) are unable to get pregnant after one year of trying (infertility)" (see CDC's Infertility FAQs). Of course, when we include those with so-called "social infertility," the number of adults needing medical reproductive assistance is higher.

Like many who do, I was not expecting to experience infertility. My partner and I needed no assistance to get pregnant with our now 7-year-old. When we decided we were ready to try for our second child, we thought it would be similarly easy. Yes, I was 35 at the time, but we knew plenty of people who'd gotten pregnant at that age, including my own mother when she had me.

When we reached 6 months of trying with no success, we made an appointment with the GW Fertility and IVF clinic. Our doctor reassured us. Our odds were good with little to no assistance and she suggested we continue to try on our own and then try monitored, medicated cycles. We followed her advice. Each cycle was another heartbreak. After three medicated cycles, our doctor said it was time to move to IVF, as it was clear that trying on our own with or without medication wasn't working.

Throughout this time, we kept quiet to friends and coworkers about what we were going through. We didn't want to tell anyone we were trying to get pregnant for all the same reasons people who aren't experiencing infertility feel the same. We didn't want to tell our employers before we were sure. We didn't want people to know in the early days of a pregnancy. We didn't want to tell our friends about failed cycles. And like many others experiencing infertility, we were so, so, so tired of the well-meaning but hurtful platitudes of "just relax" or "just adopt" or "just stop trying so hard."

The IVF pricetag is out of reach for many, including us. Our clinic estimated that one egg retrieval cycle would cost about $10,000 and we'd probably need more than one. Then there would be embryo transfers, which would each cost about $4,000 and, again, we'd probably need more than one of those.

As it went for us, we needed three retrievals and three transfers, which would have cost us about $45,000 out of pocket -- more than half my annual salary. More than many make in an entire year. **We would have gone bankrupt getting to the transfer that led to my son. But we didn't. Because I had insurance coverage through my employer that covered IVF.**

I made many friends through my infertility journey. Many have had success. Some have not. Almost all had to pay for their treatment entirely out of pocket because their employers' insurance -- even some that supposedly covered "infertility" -- did not cover IVF. Many gave up before they wanted to, simply because they could not afford further treatment.

B24-0831 would make medical treatment for infertility within reach for many, many more people than it is now. It would make the world just a little more just.

Thank you,
Mary Laura Calhoun
5026 N Capitol St. NW

MDCSCO
MARYLAND/DISTRICT OF COLUMBIA SOCIETY OF CLINICAL ONCOLOGY

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

October 25, 2022

Councilmember Kenyan McDuffie, Chairman
Committee on Business and Economic Development
Council of the District of Columbia
1350 Pennsylvania Avenue NW
Washington DC, 20004

Dear Chairman McDuffie and Members of the Committee on Business and Economic Development,

The Maryland/District of Columbia Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) urge the Committee to add fertility preservation coverage to **B24-0699, the Expanding Access to Fertility Treatment Amendment Act.** Committee passage of B24-0699 with language for fertility preservation coverage would put the District of Columbia (DC) one step closer to becoming the 12th state/region to cover fertility preservation.

MDCSCO is committed to improving the quality and delivery of care in medical oncology in the State of Maryland and the District of Columbia. ASCO is the national organization representing nearly 45,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis, and prevention.

MDCSCO and ASCO believe that as part of education and informed consent before cancer therapy, health care providers should address the possibility of infertility with both male and female patients treated during their reproductive years. Providers should also be prepared to discuss fertility preservation options and/or refer all potential patients to appropriate reproductive specialists. As such, MDCSCO and ASCO advocate for coverage of embryo, oocyte and sperm cryopreservation procedures for an insured patient who is at least eighteen years of age and has been diagnosed with cancer but has not started cancer treatment (including chemotherapy, biotherapy or radiation therapy treatment) in accordance with guidelines developed by our affiliate organization, the American Society of Clinical Oncology.

We encourage providers to advise patients regarding potential threats to fertility as early as possible in the treatment process to allow for the widest array of options for fertility preservation. MDCSCO and ASCO strongly support the addition of fertility preservation language to B24-0699 and encourage the Committee to pass this legislation to protect fertility preservation procedures for patients with cancer. Please contact Pat Troy at ptroy@nextwavegroup.net or Aaron Segel at ASCO at Aaron.Segel@asco.org if you have any questions or if we can be of assistance.

Sincerely,

Paul Celano, MD, FACP
President
Maryland/DC Society of Clinical Oncology

Lori J. Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology

Testimony for *Expanding Access to Fertility Treatment Amendment Act of 2022*
Maya Martin Cadogan

Good afternoon DC Council Committee on Business and Economic Development, Committee Chairman Kenyan McDuffie, and Councilmembers members and staff,

My name is Maya Martin Cadogan and I am a Ward 4 resident and six-generation Washingtonian. Typically, I come before the Council to testify in my capacity as the founder and executive director of PAVE (Parents Amplifying Voices in Education). However, today, I am here in my personal capacity as an expectant mother who has suffered three miscarriages between 20219 and 2021, one of the 12% of American women of reproductive age who have experienced infertility, and having been through 3 rounds of IVF with my partner, my husband James Cadogan, to conceive our first child.

One of the great injustices in our economic system is the burden that the American system places on families, especially Black, Brown, and low-income families. One of those burdens on Black women is the challenge of access to fertility treatments. While Black women are more than twice as likely to suffer from infertility as compared to White women, infertility treatment is cost prohibitive to most Black women and families given our communities' historical and glaring wealth gap. The average IVF treatment, a process which my husband and I went through three times, is around $14,000 but in the DC area, we were quoted prices around $30,000 including the medications. That does not include services like PG testing which was critical for my husband and myself as we experienced recurrent pregnancy loss due to chromosomal issues with our embryos.

As my husband and I experienced our painful losses at 6, 8, and 10 weeks, we weighed either buying a house – allowing us to put down long-term roots in the place that six generations of my family have called home – or to fund an IVF cycle. No woman or family should have to make that choice. And thankfully, due to a New York law, we did not have to. My husband now works for an organization headquartered in New York and their insurance benefits follow the policies set forth by that state. In January 2020, New York passed an infertility law requiring all employers with over 100 employees to cover three rounds of IVF and that is exactly what it took for us to transfer an embryo that we are excited to welcome to the world in December 2022. As a result of New York law, as a Black couple who purchased our first home nearly in our 40's with the savings we had built over 20 years of work, we were able to both buy a house in DC and we are excited to welcome our son into it. Don't we in DC want to make both homeownership and children possible for other families, especially Black families that we are losing at an alarming rate?

Even our neighboring state of Maryland has a fertility law on the books that requires coverage of fertility treatment by insurance carriers. I know friends who have moved to MD employers to

get coverage. Do we want to lose more families, especially Black families, to MD who would otherwise want to build a home here in DC? I do not think that is good for the economic development or businesses of DC.

As we continue to focus on racial inequities in our policymaking in DC, I urge the Council to address this racial justice issue that is disproportionately impacting families, especially Black families like my own. I am thankful that New York provided my husband and I with the option to both own a home in DC and start a family here but it would have been my hope that that option would have been provided by my favorite city on Earth, DC. I want to thank Councilmember Christina Henderson for introducing this legislation and I hope that all of her fellow Councilmembers will not only move this from the Committee to a full vote by Council but that in 2022, our Mayor and Council will sign this bill into law for the families of DC.

October 12, 2022

Dear Chairman McDuffie and members of the Committee on Business and Economic Development,

Thank you for holding this hearing. I am writing to express my support for Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022."

This draft bill is an important first step toward helping women in D.C. obtain access to the comprehensive reproductive health care coverage that they all deserve.

One in four women suffer from infertility, a medical condition that not only makes it hard to get pregnant, but also takes a terrible toll on women's mental and emotional health. I am one of many women who suffer from this condition.

And yet, our country has refused to mandate insurance coverage for infertility treatment, a discriminatory act which means that many women - particularly those with lower incomes - are deprived of the basic human right of motherhood because they do not have the means to afford the medical intervention necessary to make them mothers. Today, only 20 states mandate some form of infertility health insurance coverage, with some laws being more comprehensive than others.

Before you finalize this bill, I would urge you to consider making the following revisions that I believe will strengthen the legislation, and further expand womens' access to fertility care in the District of Columbia:

1) Explicitly ban the use of lifetime maximum caps on infertility insurance coverage by insurance companies and companies who employ District of Columbia residents. Coverage for infertility care should not be limited.

2) Prohibit specialty pharmacies, manufacturers and pharmacy benefit managers (PBMs) from charging higher prices to insured patients versus uninsured patients, a common practice that discourages patients from using insurance to cover the costs of their fertility drugs, and require insurers to provide comprehensive fertility drug coverage.

3) Require insurance companies to cover the cost of preimplantation genetic testing for aneuploidies, a key test that can reduce the chances of miscarriage, as well as the costs for donor egg services, including the purchase of the eggs themselves as well accompanying procedures including egg fertilization, biopsy, cryo-preservation, thawing, assisted hatching and embryo transfer.

4) Ban discimination against single women and same-sex couples who need access to fertility care, and ensure that companies who employ residents in the District of

Columbia do not try to circumvent this bill, either by claiming they are incorporated elsewhere, or utilizing other creative loopholes to evade the law so they may avoid offering comprehensive fertility benefits to DC-based employees.

The Problem with Lifetime Maximum Caps on Infertility Insurance Coverage

We are at the mercy of our own employers when it comes to getting access to insurance coverage for infertility treatments such as in-vitro fertilization (IVF) and Intrauterine insemination (IUI). IVF treatments are extremely expensive. The medications alone typically cost between $4,000-10,000 per round, and the medical treatments often run between $11-25K per round. Many women, particularly those over the age of 35, need multiple rounds to achieve a live birth.

Some of us, myself included, are later forced to pay tens of thousands of dollars for donor eggs after IVF treatments using our own eggs fail to lead to a successful pregnancy.

I have encountered women who have PhDs, but they are forced to take part-time jobs at Starbucks, Wayfair or Amazon just to be able to access fertility benefits. This is not something that we should tolerate in America.

The high cost of medication also means that women have resorted to purchasing leftover medication from other patients who no longer need it through an online black marketplace because pharmacies overcharge for these crucial drugs. The same exact medications cost thousands of dollars less in Europe, thanks to government-imposed price controls that we do not have in the United States.

A small handful of drug companies hold a virtual monopoly over IVF medications, and the predatory pricing practices they engage in with specialty pharmacies, insurance companies and pharmacy benefit managers (PBMs) prey on emotionally vulnerable women in America, leading them to take desperate measures such as borrowing against their 401Ks or taking out high-interest loans just to have a shot at motherhood.

Even when we are lucky enough to get some insurance coverage through our employers, it comes with a catch. The vast majority of plans place lifetime maximum financial caps on infertility care. My own employer only offers its union-covered employees, myself included, a paltry $5K lifetime max.

My husband and I were forced to take out a secondary health insurance plan with his employer, spending thousands of extra dollars, in order to afford treatments.

The lifetime maximum limits imposed on fertility insurance are draconian and unconscionable. I urge you to ban employers and insurance companies from placing limits on coverage in the final draft of your bill.

Can you imagine if you became ill, and your insurer told you it will only cover $35,000 worth of treatment for that condition for the duration of your life? That would be unthinkable. And yet, companies use these caps to place limits on how much they will pay for infertility care, in an effort to save them money at the expense of women's reproductive health.

Stop Companies From Marking Up The Cost of Fertility Medications For Insured Patients

Another troublesome practice you should be aware of is the way that pharmacy benefit managers (PBMs), specialty pharmacies, insurers and drug manufacturers find ways to price gouge insured patients for fertility drugs.

This practice not only drives up the cost of fertility care for everyone, but it also becomes a major problem if lifetime maximum caps are allowed to remain in place.

The sky-high prices for fertility medication, even when using insurance, in turn is driving patients to look for cheaper solutions, such as buying leftover medication from other patients in online black market sales, or by ordering medications from overseas.

If a woman is lucky enough to have fertility insurance coverage, most plans require patients to use in-network pharmacies if they wish to get their medications covered.

But what most patients do not know is that if they opt to use their insurance to obtain their medications, the prices will be double or even triple the cost of what a pharmacy will charge a patient paying out of pocket without insurance for the same exact drug.

For instance, a specialty pharmacy may charge a patient who is paying out of pocket $750 for a single 900-unit injectable pen of Gonal-F, a drug made by manufacturer EMD Serono that is used to stimulate the ovaries to produce multiple eggs. That is the so-called “cash market” price.

But if you use insurance to cover that same Gonal-F pen, the contracted price between the insurer and the pharmacy could be more than $500 higher per injectable 900-unit Gonal-F pen, making a single shot cost more than $1250. Most women who undergo egg retrievals need several Gonal-F pens, as well as other types of expensive medications per round of IVF treatment.

These extreme mark-ups are particularly problematic when insurers place lifetime maximum caps on fertility coverage. On paper, a $35,000 or $50,000 lifetime max for IVF may look good at first. But the higher contracted prices that insurers pay pharmacies for the drugs is the amount that gets applied towards a patient’s lifetime maximum.

These higher contracted rates are often only disclosed to patients after the transaction is complete, and by the time they go into their clinics for their egg retrievals, they discover most of their lifetime max coverage has been eaten away by the marked-up medication costs.

The drastic differences in prices between the insurance contracted prices and the cash market prices for the same exact drugs creates a perverse incentive against using insurance at all to pay for IVF medications. This is by design, and this practice should be banned.

When I called EMD Serono's customer advocacy line to complain about this last year, the representative told me there was no point in trying to use my insurance to cover my medications.

I also inquired whether it would be possible to try to purchase drugs from specialty pharmacies at the lower cash market price, and then submit them to my insurance for reimbursement. She advised me not to do this, saying the claims would either be denied or the insurer would pay out the higher contracted rate and eat into my precious, finite amount of fertility benefits.

"The best thing to do is use the benefits for procedures, and purchase medications out of pocket," she told me. "It's all political," she added.

This practice is unacceptable, and should be prohibited. By eliminating lifetime maximums on fertility coverage and mandating that insurers cover the cost of medications at the same lower prices charged to non-insured patients, this problem can be eliminated.

INSURANCE COVERAGE FOR THE GENETIC TESTING OF EMBRYOS AND DONOR EGG SERVICES SHOULD BE MANDATORY

Another common problem that many women who require fertility treatments face is discovering that insurance carriers often refuse to cover certain services, even when there is ample scientific evidence to show these services are necessary to reduce the risks of miscarriage and will help lead to successful live births.

Two such examples of this include preimplantation genetic testing for aneuploidies, and donor egg services.

Preimplantation genetic testing, or PGT-A, is now a widely accepted medical practice that is used to detect genetic abnormalities in an embryo prior to transfer. The test is crucial, and actually can save both money and emotional heartache, by determining if an embryo is viable before it is transferred into a woman's uterus.

As women age, more and more of their eggs are likely to have genetic abnormalities, and the risks of miscarriage with these eggs are high.

Yet insurance companies are refusing to cover the cost of these tests, which usually run a few thousand dollars, claiming they are experimental. There is enough data now to suggest this is not the case, particularly when they are used for testing the most common genetic abnormalities such as Trisomy 21, also known as Down syndrome.

The much higher percentage of abnormal eggs in older women is also the reason why many of us, myself included, have no choice but to use donor eggs in order to achieve a viable pregnancy.

Many insurance companies refuse to cover any services for donor eggs, even though in people like me, donor eggs are medically necessary in order to become mothers. And those that do offer some coverage still refuse to help pay for the cost of purchasing the donor eggs. The cost of buying donor eggs, fertilizing them and transferring them is on par with the costs of adoption. Both adoption and donor egg services typically cost between $20,000-$50,000 in the U.S.

In order to afford donor egg services, my husband and I had to take out a home equity line of credit and tap into some of our savings. The financial hardship has only added to our stress and anxiety, after we already spent approximately $16,000 out of pocket for the costs that insurance would not cover in our prior three failed rounds of IVF using my own eggs.

In addition to our three failed rounds of IVF, which resulted in no viable embryos for transfer, we also lost two first trimester babies conceived naturally. Patients like me are the reason donor egg services are medically necessary. And yet, the extreme limits placed on infertility insurance policies create gaps in coverage that make it hard to afford the donor egg services required.

No woman should be forced to pay tens of thousands of dollars in order to become a mother. You should ensure your bill requires insurance companies to cover all donor egg services, as well as PGTA-testing for those who desire it.

BAN DISCRIMIANTION AGAINST SINGLE WOMEN/SAME-SEX COUPLES AND PREVENT EVASION OF DC INSURANCE MANDATE

Finally, the DC Council should be aware that many insurance plans that do offer fertility coverage often discriminate against single women as well as gay and lesbian partners who wish to become parents. They do this by requiring them, for instance, to jump through hoops by forcing people to undergo numerous expensive IUI attempts before they can proceed to IVF. Or, they will refuse to pay to freeze a woman's eggs if she is unmarried, even though freezing eggs when a woman is young is much less expensive than attempting to help her get pregnant when she is older and has fewer viable eggs.

This is unfair discrimmination and it should not be permitted. Insurance companies often place too many hurdles on patients, making it hard for people to get access to treatment even though they face a biological ticking clock.

Moreover, you should make sure any new fertility coverage mandate in the district does not contain loopholes which could allow companies to avoid offering comprehensive benefits to D.C. residents. For instance, companies may try to claim they are incorporated in states where fertility benefits are not mandated. I have seen cases, for instance, in which D.C.-based employers have refused in the past to provide insurance coverage for infertility care for their employees in other states where it is mandatory, such as New York, because D.C. had no such law on the books.

I would urge the Council to ensure these practices are not permitted.

In sum, please review the draft bill's language prior to passage and ensure it will include the following measures:

1) Ban the use of lifetime maximum caps on infertility insurance coverage by insurance companies and companies who employ District of Columbia residents

2) Ban specialty pharmacies, manufacturers and pharmacy benefit managers from price-gouging on fertility meds by marking up the cost of drugs when patients wish to use insurance to purchase them, and require fertility medications to be covered by insurers without a cap

3) Require insurance to cover the cost of preimplantation genetic testing as well as the costs of donor egg services, including the purchase of the eggs themselves as well as the accompanying services such as egg fertilization, biopsy, cryo-preservation, freezing, thawing and embryo transfer

4) Ban discimination against single women and same-sex couples who need access to fertility care and make sure companies do not find ways to evade compliance with the law.

Thank you for having the courage to take up this important measure, and I urge the D.C. Council to pass it promptly.

If you need any further information, please do not hesitate to reach out.

Sincerely,
Sarah N. Lynch
Ward 5 resident
2216 Randolph Street NE, Washington, D.C., 20018
201-841-7479
SarahNLynch@gmail.com

Bill 24-0699 Testimony of Stephanie Oldano

October 23, 2022
The Committee on Business and Economic Development
1350 Pennsylvania Avenue
Washington, DC 20004

Dear Councilmember McDuffie and Committee Members,

My name is Stephanie Oldano. I am a resident of D.C. and someone who has been diagnosed with infertility.

According to the U.S. Department of Health & Human Services, infertility means not being able to get pregnant after one year of trying (or six months if a woman is 35 or older). Women who can get pregnant but are unable to stay pregnant may also be infertile. About 10 percent of women (6.1 million) in the United States, ages 15-44, have difficulty getting pregnant or staying pregnant.

According to CCRM Fertility Clinic, The average cost for an IVF cycle with fresh eggs is around $15,130, while a cycle with frozen eggs is slightly less expensive at $13,180. This does not include the costs of medications and tests. The average price of a new patient consultation is roughly $350, and additional medications and fertility testing fees are expensive. For my partner and I, our costs will easily be above $25,000 for one round of IVF.

Infertility causes a tremendous strain on a person's financial situation and a huge emotional burden. After months of appointments and tests, I was told that I have a blocked uterine tube, diagnosed with infertility, and told it would be difficult for me to conceive naturally. Month after month, I have faced the pain of negative pregnancy tests, unpleasant hospital procedures, unending phone calls, and being on hold waiting for insurance companies and medical offices. I am a 32-year-old woman with dreams of growing a family and am currently faced with the decision of how to afford the medical treatment I need.

My partner is employed by a prominent D.C. environmental non-profit, and I am a federal employee. We have nearly the best insurance available to anyone. Yet, these treatments are not covered by our insurance, and will cost us all of our savings and any chance we had at making a down payment on a house in the DMV, which could lead to us leaving our life of nearly a decade here in this city.

Fertility treatment is essential medical treatment. The passage of this bill will be a step in the direction of placing guidelines on insurance companies, as well as directing a spotlight on the inadequacies of fertility care in our city.

The state of fertility care, maternal care, and the philosophy of birth in the country are at a crossroads. Nineteen states, including our neighbors in Maryland and West Virginia, have

passed fertility coverage mandates. The fight for affordable and humane healthcare in this country has been a long and costly one, as has the struggle for women's rights, bodily autonomy, children's rights, and human rights. I urge this council to support Bill 24-0699.

Sincerely,
Stephanie Oldano

From:	Tobin Van Ostern
To:	Commmittee on Business and Economic Development
Subject:	Testimony - Hearing Tuesday, October 25, 2022, at 1:00 p.m on B24-0699
Date:	Thursday, October 13, 2022 2:42:55 PM

Hi - I am emailing to submit comments on B24-0699.

I'm one of the owners of a DC-based tech startup that has nearly 30 employees. As a result, all insurance we offer to our employees is via the DC Exchange for small businesses. Therefore, I am writing in to urge you to pass B24-0699 to expand coverage for fertility treatment to these plans. By the nature of the program, we are unable to specifically negotiate or add this to our coverage. In order to provide proper care, and remain competitive with benefits, we think this would be a strong addition to the plans being offered.

Thank you
-Tobin Van Ostern
Co-Founder, Savi Solutions PBC

October 25, 2022

Testimony before the Committee on Small Business & Economic Development

To: Kenyan McDuffie, Ward 5 Council Member of the District of Columbia
Chairperson-Committee on Small Business & Economic Development
1350 Pennsylvania Avenue NW, Washington, DC 20004

Re: Expanding Access to Fertility Treatment

Good Afternoon CM McDuffie-Thank you for hosting this hearing so that our comments may be entered for the permanent record.

I wanted to share for the record–how this legislation can make the difference for thousands of women who are DC residents. .

What many people do not know is that I suffer from circumstantial infertility. Infertility is stigmatized and due to that many of us stay silent.

Life threw me several curveballs in regards to my journey to motherhood. In the last 15 years I have lived through the following:

1. Financial instability
2. Going without health insurance because I couldn't afford it
3. Survived an attempted sexual assualt
4. Terminally Ill parent

After my father passed away from stage 4 brain cancer, I could stop being the dutiful daughter and recenter my own life.

The factors of age, career choices, and financial instability labeled me as an "unsuitable" prospect in my culture.

Many will tell you that I'm rather bohemian and decided motherhood would look different for me.

However when I started the research I would discover the following:

1. Just to get tested for egg quality is $500

2. The medication and just freezing my eggs would be at a minimum of $15,000

Those are the financial price tags, but we don't talk about the emotional price tags around infertility.

To be told by medical professionals that my "time window" is essentially non-existent to have a child from my own body.

My doctors would tell me that I'd have to have at least $100,000 to have a child at this point.

The choice in having children is incredibly personal, and to feel that finances would most likely be the reason I won't be a mother is hard to accept.

This legislation would make the difference for so many women-I wish it were in time for me to benefit from it, but I'm more than happy to echo my support for it.

I'm prepared to address any questions you may have.

In Service:

Trupti J. Patel, ANC 2A, SMD 03

From:	Zo Clement
To:	Commmittee on Business and Economic Development
Subject:	Testimony for Hearing on Bill 24-0699, the “Expanding Access to Fertility Treatment Amendment Act of 2022”
Date:	Thursday, October 13, 2022 5:28:17 PM

Good evening councilmembers,

I am writing to provide written testimony on Bill 24-0699, the “Expanding Access to Fertility Treatment Amendment Act of 2022”. I received notice that this bill would come to a public hearing on Tuesday, October 25.

I am a middle school special education teacher at Two Rivers Public Charter School, as indicated by my email signature. I have worked as a special education teacher in Washington, DC for 13 years, and have worked at Two Rivers PCS for five.

I want to keep working where I work at Two Rivers Public Charter, and view staying at my school as a powerful way to provide continuity and stability for my students; especially during this time of extreme teacher shortage and instability in the public education system. However, I am over the age of 35, have genetic preconditions that make conception difficult and risky, and have been told by my doctor that I should pursue IVF to build my family. Since IVF is not covered by my DC insurance, but is covered in Maryland, I am strongly debating whether to change jobs to Maryland to get IVF covered as soon as I can.

I am asking that you move swiftly on this bill to pass it, so that myself and others in similar situations are able to meet both our family-building dreams as well as continue our important work in DC.

Given current threats to our democracy and the fact that inequitable access to fertility treatment majorly impacts low income and communities of color, the issue addressed by Bill 24-0699 is prevalent.

Thank you so much.

photo

Zo Clement
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Learn with Two Rivers

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Insurance, Securities and Banking

Hearing on

Bill 24-0829, the "Medical Malpractice Clarification Amendment Act of 2022"
Bill 24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022"
Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"

Testimony of

Philip Barlow
Associate Commissioner, Insurance
Department of Insurance, Securities and Banking

Before the

Committee on Business & Economic Development
Councilmember Kenyan R. McDuffie, Chairperson
Council of the District of Columbia

October 25, 2022
1:00 PM

Via Virtual Meeting Platform

Good afternoon, Chairperson McDuffie, and members of the Committee on Business & Economic Development. My name is Philip Barlow, and I am the Associate Commissioner for Insurance at the Department of Insurance, Securities and Banking, or DISB. DISB regulates insurance, securities, banking, and other financial services in the District of Columbia. Our mission is three-fold: (1) to cultivate a regulatory environment that protects consumers and attracts and retains financial services firms to the District; (2) to empower and educate residents on financial matters; and (3) to provide financing to District small businesses.

Thank you for the opportunity to testify today on the following bills:

- Bill 24-0829, the "Medical Malpractice Clarification Amendment Act of 2022"
- Bill 24-0831, the "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022"
- Bill 24-0699, the "Expanding Access to Fertility Treatment Amendment Act of 2022"

B24-0829"Medical Malpractice Clarification Amendment Act of 2022"

The Medical Malpractice Clarification Amendment Act of 2022 would prohibit medical malpractice insurers from taking adverse action against a health professional who provides legal abortion care. DISB supports the bill but has a few points that it would for the committee to consider.

The adverse action specifies "health professional" which is defined as anyone licensed or permitted to practice a health occupation by the Department of Health. While most health professionals likely will have medical malpractice

coverage on themselves, some entities (*e.g.*, clinics) may have their own medical malpractice policy not tied to a particular health professional. Therefore, we recommend amending the legislation to add the phrase, "or a facility that engages health professionals" after the phrase "against a health professional" in the new section 3a.

B24-0831 "Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022"

The Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022 would require private insurance companies to cover abortion care without imposing cost-sharing requirements. The Department also supports this bill.

With regard to the Affordable Care Act (ACA), elective abortion is currently covered in the District's benchmark plan, although it is not one of the essential health benefits (EHBs) under the ACA. The ACA requires all health insurance plans sold on a state or federal exchange to meet minimum standards, or EHBs. States that require insurance plans to offer benefits above and beyond the EHBs, must, in most cases, pay for them. Specifically, the state assumes the cost of any amount attributable to the benefit's impact on premium for recipients of Advance Premium Tax Credits.

So, although elective abortion is in the benchmark plan, since it is not an EHB we currently have some ACA plans that do not cover abortion services or cover with cost sharing. Some other plans that exclude abortion services include student health plans, and some large group or self-funded plans.

The legislation will likely require some time for adjustments to plan documents by the insurers. Typically, when new requirements are included, some time is provided for insurers to bring forms into compliance, but that is unlikely to be provided for this legislation, so there will be some inconsistency between the law and policy language for a while. Also, there are many people in the District who are not covered by plans we regulate, including Medicaid recipients, Federal Employees Health Benefit Program employees and retirees, self-insured plans and residents who work for employers based in other states.

Note that some services may not be required without cost-sharing requirements for certain High Deductible Health Plans (HDHP) with a joint Health Savings Account (HSA). As such, these plans should likely be explicitly excluded from the requirement of covering abortion care without cost-sharing. For additional information, see IRS Publication 969 (2021) and related materials.

B24-0699 "Expanding Access to Fertility Treatment Amendment Act of 2022"

The Expanding Access to Fertility Treatment Amendment Act of 2022 would expand coverage provided through private insurers, Medicaid, and the DC Healthcare Alliance to include diagnosis and treatment for infertility. It would also prohibit health insurers from imposing additional costs or certain limitations on coverage and from placing pre-existing condition exclusions or waiting periods on coverage. Please note that as a new mandate there will likely be a financial cost to the District specific to the ACA plans sold on DC Health Link in the individual and small group markets. While benefits are currently available for the diagnosis of infertility, they are limited to infertility counseling and testing; and the District's benchmark plan explicitly excludes coverage for:

All assisted reproductive technologies including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services, and medical preparations related to the same.

DISB does not know at this time what the cost attributable to the new mandate might be, but we do know that nearly 3,300 people on the Exchange receive an Advanced Premium Tax Credit (APTC), as of October 2022; and the average total subsidy is around $343[1] per recipient.

[1] https://www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22district-of-columbia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Similar to the Reproductive Health Care Insurance Coverage Expansion Amendment Act of 2022, the proposed effective date of this new benefit would result in an inconsistency between the law and policy language for a period and this will cause premiums to increase.

Conclusion

The Department is fully supportive of the Council's efforts to increase access to care and hope that we have offered information and valuable suggestions in our testimony. Thank you for the opportunity to testify on these bills and I am happy to answer any questions you may have.

ATTACHMENT
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BILL 25-0034

RACIAL EQUITY IMPACT ASSESSMENT
EXPANDING ACCESS TO FERTILITY TREATMENT AMENDMENT ACT OF 2023

TO: The Honorable Phil Mendelson, Chairman, Council of the District of Columbia

FROM: Namita Mody, Director, Council Office of Racial Equity

DATE: May 31, 2023

COMMITTEE

Committee on Health

BILL SUMMARY

Bill 25-0034 requires private health insurers to provide coverage for the diagnosis and treatment of infertility, including medically necessary ovulation drugs, in vitro fertilization, and standard fertility preservation services. The bill also requires Medicaid coverage for the diagnosis and treatment of infertility and medically necessary ovulation drugs. In addition, the bill states that health insurers must not limit coverage or discriminate against people seeking coverage. Lastly, the bill requires the District Department of Health Care Finance to determine possible funding and coverage options for in vitro fertilization and standard fertility preservation services under DC Medicaid.

CONCLUSIONS

- Bill 25-0034 will likely improve access to infertility treatments for Black, Indigenous, Latine, and other residents of color that have health insurance. However, cost may still remain a barrier for residents of color—including LGBTQ+ residents of color.
- Bill 25-0034 maintains the status quo of access and affordability of infertility diagnosis and care for Black, Indigenous, Latine, and other residents of color without health insurance.
- Bill 25-0034's reporting requirement for the Department of Health Care Finance will have an inconclusive impact on Black, Indigenous, Latine, and other residents of color.

FURTHER CONSIDERATIONS

- The Center for Disease Control and Prevention's National Public Health Action Plan suggests that integrating fertility screening and treatment services into primary care settings can maximize fertility treatment outcomes.
- Bill 25-0034 does not mandate action following the Department of Health Care Finance's research and report on the medical necessity for IVF and standard fertility preservation services.
- Without an intentional focus on the ways in which racism has been engrained into obstetrics, gynecology, midwifery, endocrinology, and the health care system broadly, improvements in fertility and birth outcomes could potentially be minimal for Black residents.

Content Warning: The document you are about to read is a Racial Equity Impact Assessment, a careful and organized examination of how Bill 25-0034 will affect different racial and ethnic groups. We hope that this assessment sparks a conversation that is brave, empathetic, thoughtful, and open-minded.

The following content touches on racism, infertility, chattel slavery, the Civil War, the Jim Crow era, medical racism, experimentation, homophobia, transphobia, sexual violence, domestic violence, eugenics, the Puerto Rican Birth Control Trials, sterilization, birth mortality, and other forms of violence. Some or all of these issues may trigger a strong emotional response. We encourage you to use this knowledge in the way that is most helpful to you.

Note on Data Used in this Assessment: In this REIA, CORE heavily references the experiences of people that identify as cisgender,[1] given that most of the research on infertility to date focuses on cisgender people. Specifically, the data used in this assessment primarily references the experiences of cisgender women. However, CORE recognizes that people of all gender identities can experience infertility. Therefore, this REIA discusses that people of all gender identities experience infertility diagnosis, receive treatment, and need access to fertility-enhancing medications, fertility preservation, and procedures.

Note on the LGBTQ+ Acronym Used in this Assessment: The acronym "LGBTQ+" refers to Lesbian, Gay, Bisexual, Transgender, Questioning plus other individuals marginalized for their sexual orientation, gender identity, gender expression, and sex characteristics. Despite being grouped together, CORE recognizes that each community within the larger LGBTQ+ community has a unique history and experience of oppression in the United States and the District of Columbia. Therefore, it is unlikely that data sources on LGBTQ+ individuals in this REIA fully capture the experience of all District residents in the LGBTQ+ community.

Given the goal of differentiating the experiences of LGBTQ+ people, sources in this REIA use different acronyms such as LGB, LGBT, LGBTQ, and LGBTQ+, among others. To ease readability, this REIA will use LGBTQ+.

BACKGROUND

FIGURE A Glossary

KEY TERMS	DEFINITION
HEALTH INSURER	Any person that provides one or more health benefit plans or private insurance in the District of Columbia. (source) This does not include an employer that is self-funded or self-insured, meaning this does not cover an employer that pays its own insurance claims through a third party administrator. (source)
ASRM	The American Society for Reproductive Medicine, which is a nonprofit organization that provides "information, education, advocacy, and standards in reproductive medicine and science." (source)
INFERTILITY	As defined in Bill 25-0034, it is a disease, condition, or medical status where a person cannot become pregnant or carry a pregnancy all the way to the live birth "after regular, unprotected sexual intercourse in accordance with the guidelines of ASRM." This includes someone who cannot reproduce without medical intervention as a single individual or with their partner. This also includes people diagnosed as infertile through testing or physical examination by their doctor. (See the Committee Print for Bill 25-0034.)

[1] Cisgender people are people whose current gender identity corresponds to the sex that the person had or was identified as having when they were born (see Merriam-Webster).

KEY TERMS	DEFINITION
	As defined by the Centers for Disease Control and Prevention (CDC), infertility is defined as a condition in which a person cannot get pregnant within one year of having unprotected intercourse. (source) CORE notes that the bill's definition of infertility is broader than the CDC's, and is inclusive of same-sex couples and people that wish to pursue parenthood in other ways.
ASSISTED REPRODUCTIVE TECHNOLOGY	As defined by the CDC, assisted reproductive technology (also known as ART) is any fertility treatment that handles or manipulates eggs or embryos. It does not include fertility treatments that only handle or manipulate sperm. (source) Embryos are a stage of human development between the implantation of a fertilized egg and the eighth week that has passed after. (source) Importantly, the bill does not name the term 'assisted reproductive technology,' but the research that is referenced throughout this REIA refers to assisted reproductive technology. For this reason, CORE is defining the term.
INFERTILITY TREATMENTS	In terms of Bill 25-0034, covered treatments for infertility are "established medical practices" offered by licensed physicians and surgeons. These treatments include diagnostic tests, medication, surgery, or gamete intrafallopian transfer. (See the Committee Print for Bill 25-0034.)
GAMETE INTRAFALLOPIAN TRANSFER	Gamete intrafallopian transfer is a type of assisted reproductive technology. In this procedure, an egg and sperm are removed, mixed in a catheter (which is a tube that removes or puts fluids into the body), then immediately placed into the fallopian tubes. (source)
IN VITRO FERTILIZATION	In vitro fertilization (also known as IVF) is a type of assisted reproductive technology. In this procedure, an egg is fertilized by sperm in a laboratory dish, instead of inside of someone's body. (source)
OOCYTE RETRIEVAL	An oocyte retrieval is when eggs are taken from someone's ovaries. This is a step in the process of in vitro fertilization. (source)
EMBRYO TRANSFER	An embryo transfer is a part of the IVF process after an egg becomes fertilized by sperm, when the embryo is moved into the person's body for implantation. (source)
FERTILITY TREATMENT CYCLES	Fertility treatment cycles are the combined steps needed to complete a particular fertility treatment option. For IVF, a cycle of treatment includes stimulating ovulation, oocyte retrieval, fertilization, and the implantation of the fertilized egg. (source) For gamete intrafallopian transfer, a cycle of treatment includes oocyte retrieval, followed by joining the sperm with the egg in a catheter, and then placing of the egg and sperm into the fallopian tubes. (source)
STANDARD FERTILITY PRESERVATION SERVICES	According to the bill, these services include "established medical practices" or procedures that have been established through guidelines published by ASRM or the American Society of Clinical Oncology "for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility." An example of this is preserving someone's eggs prior to them starting chemotherapy so that they may still possibly conceive a child through a future fertility treatment. (source)
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)	The Centers for Medicare & Medicaid Services (CMS) is a federal agency in the Department of Health and Human Services. CMS provides regulations, guidance, research, outreach, and other services related to Medicare and Medicaid. (source)
MEDICAID	Medicaid is a health insurance program that people may be eligible for based on their income. Children may also be eligible based on their parent or legal guardian's income. (source)

KEY TERMS	DEFINITION
MANAGED CARE ORGANIZATIONS	Generally, managed care organizations offer a way for people enrolled in a particular health insurance to get care by doctors and specialists that are considered 'in-network' by their health insurer. (source) Managed care organizations that are a part of the District's Medicaid Managed Care Program accept responsibility over the cost of services provided to people who are members of the organization and enrolled in Medicaid. (source)
DC HEALTH CARE ALLIANCE	The DC Health Care Alliance is a program that helps cover the cost of medical services for residents that are not eligible for Medicaid or Medicare. (source)
DEDUCTIBLE	The amount someone is required to pay for health care before their insurance pays for health care. Only payments for services that would be covered by the health insurance go toward the deductible. (source)
COPAYMENT	First, the deductible must be met. After the deductible amount is paid, an insurance plan may have a copayment, also known as a copay. This is a set amount that someone pays for certain health care services. Different health care services may have their own copayment amount. The services must be covered by health insurance for someone to only be obligated to pay the copay. (source)
COINSURANCE	Similarly, your insurance plan may have coinsurance after you meet your deductible. This is a set percentage that you pay for all health care services. Coinsurance does not change depending on the health care service (for example, medication and doctor visits) and your insurance must cover the health care service for you to only need to pay the coinsurance percentage. (source)
BENEFIT LIMIT MAXIMUM	The set dollar amount that insurance will spend on things covered by the insurance plan. A year dollar limit is this set dollar amount for a year of being insured by the insurance plan. A lifetime limit is this set amount for the lifetime of the insurance plan. (source)

The following content describes Bill 25-0034 in plain language for the purposes of discussion. This explanation is not a substitute for the bill, or if passed, the law.

Bill 25-0034 requires private health insurers to provide coverage for the diagnosis and treatment of infertility by January 1, 2025. Treatments include in vitro fertilization (IVF) and "standard fertility preservation services."[2]

Specifically, treatments that shall be covered include:

- at least three oocyte retrievals and unlimited embryo transfers from them
- unlimited embryo transfers from any oocyte retrievals that take place before January 1, 2025
- an embryo transfer from an individual to a third-party (such as a surrogate[3]).

Bill 25-0034 also requires health insurance through Medicaid and the DC Health Care Alliance to offer coverage for the diagnosis of infertility and "medically necessary ovulation enhancing drugs" by January 1, 2024. This includes coverage for services at different stages in a fertility treatment cycle, such as the prescription of at least three cycles of ovulation enhancing medication over a person's lifetime. This does not include IVF and standard fertility preservation services, but the bill includes a reporting requirement to consider how this coverage may be given after the bill passes (further discussed below).

Next, the bill specifies that the diagnosis and treatment of infertility is exempt from any *additional* deductibles, copayments, coinsurance, benefit maximums, waiting periods, or other limitations to coverage

[2] See the Committee Print for Bill 25-0034.
[3] Ibid. This coverage only covers the embryo transfer—it does not cover other surrogate medical costs, lifestyle costs, or other costs that may come from working with a surrogate.

(that are not already included in the insurance plan). This means that these tools and limitations cannot be changed in a way that targets people seeking coverage specifically for infertility diagnosis and treatment.

In addition, all coverage for the diagnosis and treatment of infertility must be provided without discrimination on the basis of "age, ancestry, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation."[4] Coverage also cannot exclude people due to pre-existing conditions and prior diagnosis and treatment of infertility—including through the method of waiting periods due to pre-existing conditions. Lastly in this section, the bill specifies that insurers cannot limit coverage due to factors such as cost or age. Coverage also cannot be differentiated or have different requirements for people protected under the DC Human Rights Act of 1977.[5]

Notably, insurers must let all policyholders and prospective policyholders that are in the stages of negotiation know about these coverage options.

Finally, the bill outlines requirements for the District Department of Health Care Finance (DHCF) that must be met within 180 days of the bill's passing. The agency must submit a report in consultation with the Centers for Medicare & Medicaid Services (CMS), which should include:

- an explanation of whether IVF and standard fertility preservation services are "medically necessary and reasonable" under federal law
- ways that these services could be covered under DC Medicaid and managed care organizations
- ways to ensure targeted groups may get coverage for these services under DC Medicaid and managed care organizations
- the amount of money needed to provide coverage of these services.

A Brief History of Infertility and Reproductive Experiences by Race

CORE recognizes that people of all gender identities can experience infertility. In this section of the REIA, CORE heavily references the experiences of people that identify as cisgender women,[6] given that most of the research on infertility to date focuses on cisgender people (and cisgender women in particular). Later on, this REIA discusses that people of all gender identities experience infertility diagnosis, receive treatment, and need access to fertility-enhancing medications, fertility preservation, and procedures.

***Content Warning**: The section you are about to read touches on racism, infertility, chattel slavery, the Civil War, the Jim Crow era, medical racism, experimentation, homophobia, transphobia, sexual violence, domestic violence, eugenics, the Puerto Rican Birth Control Trials, sterilization, and other forms of violence. Some or all of these issues may trigger a strong emotional response. We encourage you to use this knowledge in the way that is most helpful to you.*

[4] Ibid.

[5] Traits, classes, and circumstances that are protected against discrimination under the DC Human Rights Act of 1977 include age, skin tone, credit information, disability status, family responsibilities, familial status, gender identity and expression, genetic information (such as risk of a particular disease), residence status (such as if someone is homeless), marital status, matriculation (such as not being in a higher education program), national origin, personal appearance, the geographical location of one's home/job, political affiliation, race, religion, sealed eviction record, biological sex, sexual orientation, source of income, whether or not someone is a victim of domestic violence, sexual offense or stalking, and whether or not someone is a factor of violence within their family. For more, see the Office of Human Rights' description of Protected Traits in DC.

[6] Cisgender people are people whose current gender identity corresponds to the sex that the person had or was identified as having when they were born (see Merriam-Webster).

Chattel slavery, the Civil War, and the Jim Crow era all heavily contribute to present day differences in fertility and birthing outcomes for Black people, Indigenous people, and other people of color, particularly when compared to white people's fertility experiences.[7]

Historically, enslaved Black women were used for experimentation to perfect the white-led practices of obstetrics and gynecology.[8,9] Black enslaved women were also experimented on to treat infertility, given that chattel slavery relied on them as a less expensive 'mechanism' to increase enslaved labor than an enslaver buying more enslaved people.[10] This is because children born to enslaved women were considered enslaved and owned by their mother's enslaver the moment they were conceived and born.[11] For this same reason, Black enslaved women were often sold by their enslavers and separated from their families and communities due to suspected infertility.[12] These factors all compounded to mass experimentation on Black enslaved women's bodies which, among other factors, propelled several patterns of racial disparities that we currently see in maternal mortality, infant mortality, and infertility.[13]

Following chattel slavery, the disparities between Black and white women's reproductive health outcomes were further exacerbated due to differences in dependence on large-scale farm labor. Many white women's families owned smaller farms or lived in more urban areas.[14] This means that on average, white women gained more autonomy over their reproductive choices because their families had more autonomy over the types of farm labor, if any, that they relied on.[15] This led to less dependence on childbearing and lower rates of infant mortality.[16] On the other hand, Black women's families continued to heavily rely on large-scale farm labor (which closely mirrored the physical labor used to run plantations during chattel slavery).[17] This means that Black women and their families continued to have little to no autonomy over their reproductive choices, partially because their family's livelihood continued to depend on physical labor.[18] The lack of reproductive autonomy experienced by Black women contributed to continuously high rates of Black infant mortality.[19] The racial inequities in reproductive autonomy also fueled disparities in resources, such as income and status, which further contribute to disparities in infant mortality.[20]

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[7] Cheryl Elman, Robert A. McGuire, and Andrew S. London. "Disease, Plantation Development, and Race-Related Differences in Fertility in the Early Twentieth-Century American South." American Journal of Sociology 124, no. 5 (March 2019): 1327–71.
[8] Obstetrics and gynecology, often abbreviated as OB/GYN, includes two separate fields of medical care. Obstetrics involves care during when someone is trying to get pregnant, when they are pregnant, during childbirth, and immediately after childbirth. Gynecology involves care of all reproductive and sexual health issues. For more on the field, see Obstetricians and gynecologists: What's the difference? from UCLA.
[9] Prather, Cynthia, Taleria R. Fuller, William L. Jeffries, Khiya J. Marshall, A. Vyann Howell, Angela Belyue-Umole, and Winifred King. "Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity." Health Equity 2, no. 1 (December 2018): 249–59.
[10] Schwartz, Marie Jenkins. Birthing a Slave: Motherhood and Medicine in the Antebellum South. Harvard University Press, 2010.
[11] For more background, see: Thavolia Glumph, *Out of the House of Bondage: The Transformation of the Plantation Household, Cambridge University Press,* 2008; Hannah Rosen, *Terror in the Heart of Freedom: Citizenship, Sexual Violence, And the Meaning of Race in the Postemancipation South*, The University of North Carolina Press, 2009; and Kenneth Stampp, *The Peculiar Institution: Slavery in the Ante-Bellum South*, Vintage Books, 1956.
[12] Schwartz, Marie Jenkins. Birthing a Slave: Motherhood and Medicine in the Antebellum South. Harvard University Press, 2010.
[13] For more on this, see CORE's REIA on Bill 24-0143, the Certified Midwife Credential Amendment Act of 2021.
[14] Cheryl Elman, Robert A. McGuire, and Andrew S. London. "Disease, Plantation Development, and Race-Related Differences in Fertility in the Early Twentieth-Century American South." American Journal of Sociology 124, no. 5 (March 2019): 1327–71.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Ibid.

Chattel slavery's dependence on Black enslaved women's reproductive outcomes and fertility, followed by Black families' continued economic reliance on physical labor due to Jim Crow's mass and intentional exclusion of Black people from other ways to earn a living, contributed to many myths around Black women's fertility. Specifically, these events contributed to the belief that Black women are inherently and extremely fertile—a myth that we see perpetuated today.[21]

Latine women also face myths of being inherently, extremely fertile. An event that contributed to this myth is the Puerto Rico Birth Control Trials. These medical trials were founded on the ideas of eugenics[22]—which is the incorrect belief that humans can be improved by not allowing Black, Indigenous, Latine, and other people of color to reproduce, along with people that are poor, mentally ill, or experiencing a chronic illness or disease. This belief gave way to the trials, as a desire to control the population of Puerto Ricans and people living in poverty.[23] Puerto Rican women were a part of the trials without their informed consent.[24] Women in the poorest areas of San Juan were targeted to participate,[25] and related research highlights that Afro-Puerto Ricans disproportionately lived in the poorest neighborhoods.[26] The medical racism that fueled these events led to myths about Latine women being extremely fertile.[27]

Indigenous women have also faced harsh and traumatic experiences related to fertility and infertility. One example illustrates how the incorrect ideology of eugenics and medical racism led to US policy decisions resulting in the mass sterilization of Indigenous women.[28] Specifically, the Family Planning Services and Population Research Act of 1970 contributed to the sterilization of over 25% of Indigenous women between 1970 and 1976.[29] The Act offered funds to cover sterilization, but often Indigenous women who received health care through the Indian Health Service were forced to agree to sterilization without the option to fully and actively give informed consent.[30] Research highlights that some even agreed under duress—meaning they agreed in a heightened emotional state or were pressured to agree to sterilization.[31] These circumstances show that informed consent[32] was often not given, which led to mass forced sterilizations.

Medical racism has contributed to myths about Black, Indigenous, Latine, and other of people color for centuries. It also contributes to negative health outcomes that are disproportionately experienced by Black, Indigenous, Latine, and other people of color. While these examples highlight the *historical* experiences of Black, Indigenous, and Latine women, these systems and ideologies continuously impact Black, Indigenous, Latine, and people of color of all gender identities today.

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[21] Chicago Tribune. "Here's Why Many Black Women Are Silent about Their Struggle with Infertility," June 29, 2019.
[22] Genome.gov. "Eugenics and Scientific Racism," September 14, 2022.
[23] The First Birth Control Pill Used Puerto Rican Women as Guinea Pigs; History. March 11, 2009.
[24] Ibid.
[25] Ibid.
[26] Minority Rights Group International. "Puerto Rico: Afro-Puerto Ricans." Minority Rights Group, June 19, 2015.
[27] Michael J. Montoya, Lydia Zacher Dixon, and Natali Valdez. "Pregnancy - Latino Studies," April 27, 2017.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] The American Medical Association's Journal of Ethics highlights that informed consent must include four elements: 1) voluntariness (the decision is free from coercion or pressure), 2) disclosure (the clinician's sharing of information relevant to the patient's decision), 3) understanding (the patient must comprehend what they are consenting to), and 4) capacity (the patient can fully consider the decision). Decisions made under duress or emotional distress are not made voluntarily and with capacity. For more, see *Bester, Johan, Cristie M. Cole, and Eric Kodish. "The Limits of Informed Consent for an Overwhelmed Patient: Clinicians' Role in Protecting Patients and Preventing Overwhelm." AMA Journal of Ethics 18, no. 9 (September 1, 2016): 869–86.*

Infertility Experiences by Race and Ethnicity

The diagnosis and treatment of infertility requires several steps, all of which are physically, emotionally, and financially draining. The process of seeking diagnosis and treatment of infertility is also filled with racial, cultural, and linguistic barriers.

Infertility among people with a uterus can be caused by a variety of factors—including chronic disease and medical treatments such as cancer treatment.[33,34] In some cases, the cause of infertility for a particular person may not be diagnosable.[35] Studies highlight that Black women are less likely to seek diagnosis and treatment of infertility when compared to white women.[36,37] Of those that have sought out diagnosis, however, one national study reports that Black women are 1.45 times more likely to experience infertility when compared to white women.[38] The same study found that Indigenous[39] women are 1.35 times more likely to experience infertility when compared to white women.[40] Other studies highlight similar findings, such as Black and Latina women being more likely to experience infertility than white women.[41,42]

Data on the racial differences in fertility diagnosis and care for cisgender men in the US is limited. This is partially due to the fact that data and reports on cisgender fertility diagnosis and treatment includes many gaps.[43] Examples of these gaps include missing information in insurance databases and reliance on questionnaires where people must opt in to answer questions about their experiences with infertility.[44] Another contributing factor is the accessibility of health care services for cisgender men of color.[45] With that being said, research highlights that infertility among cisgender men can be caused by a variety of factors—such as the use of certain medications and sperm quality.[46] In terms of seeking infertility treatment, one study found that Black and Indigenous cisgender men are less likely to seek infertility treatment than white cisgender men.[47]

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[33] Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What Are Some Possible Causes of Female Infertility?" National Institutes of Health, January 31, 2017.
[34] Lee Warner, Denise J. Jamieson, and Wanda D. Barfield. "CDC Releases a National Public Health Action Plan for the Detection, Prevention, and Management of Infertility." Journal of Women's Health, July 14, 2015.
[35] Weigel, Gabriela, Usha Ranji, and Michelle Long. "Coverage and Use of Fertility Services in the U.S." Kaiser Family Foundation, September 15, 2020.
[36] Chicago Tribune. "Here's Why Many Black Women Are Silent about Their Struggle with Infertility," June 29, 2019.
[37] American Psychological Association. "Infertility and Black, Indigenous & People of Color," n.d.
[38] LaTasha B. Craig, Jennifer D. Peck, and Amanda E. Janitz. "The Prevalence of Infertility in American Indian/Alaska Natives and Other Racial/Ethnic Groups: National Survey of Family Growth." Paediatric and Perinatal Epidemiology 33, no. 2 (March 2019): 119–25.
[39] Although the data cited in this source uses the terms "American Indian" and "Alaskan Natives," CORE is using the term "Indigenous" throughout this REIA. For more on the term "Indigenous," please see Merriam-Webster.
[40] LaTasha B. Craig, Jennifer D. Peck, and Amanda E. Janitz. "The Prevalence of Infertility in American Indian/Alaska Natives and Other Racial/Ethnic Groups: National Survey of Family Growth." Paediatric and Perinatal Epidemiology 33, no. 2 (March 2019): 119–25.
[41] American Psychological Association. "Infertility and Black, Indigenous & People of Color," n.d.
[42] Chandra, Anjani, and Elizabeth Hervey Stephen. "Infertility and Impaired Fecundity in the United States, 1982–2010: Data From the National Survey of Family Growth," no. 67 (2013).
[43] Najari, Bobby B. "Racial Differences in Men Seeking Fertility Treatment in North America: A Timely Report by the Andrology Research Consortium." Fertility and Sterility 116, no. 5 (November 2021): 1295–96.
[44] Ibid.
[45] Ibid.
[46] Weigel, Gabriela, Usha Ranji, and Michelle Long. "Coverage and Use of Fertility Services in the U.S." Kaiser Family Foundation, September 15, 2020.
[47] Najari, Bobby B. "Racial Differences in Men Seeking Fertility Treatment in North America: A Timely Report by the Andrology Research Consortium." Fertility and Sterility 116, no. 5 (November 2021): 1295–96.

Transgender and nonbinary people may experience infertility due to all of the same factors as cisgender women and men. Additionally, if a transgender or nonbinary person receives health care services such as hormone therapy, their fertility can be temporarily or permanently impacted.[48] While this experience is not definitive for people who receive hormone therapy, it is a possible cause of infertility in addition to chronic disease, medication use, sperm quality, and other causes.[49] Unfortunately, data is limited on the specific infertility experiences of people of color[50] that identify as transgender and nonbinary. However, CORE recognizes that the infertility-related racial inequities faced by cisgender people of color are likely further exacerbated for transgender and nonbinary people of color.

It is critical to note that race is not biological and therefore does not cause infertility. However, systemic racism impacts everything from economic resources to health care access and one's environment. According to Kaiser Family Foundation's 2021 briefing on how race is used in medical data gathering, "although race is not tied to biologic differences, understanding differences in health and health care by race and ethnicity remains important for identifying and addressing disparities in health and health care that stem from racism and social and economic inequities."[51] For more on this topic, see "Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications."

The Costs of Infertility Diagnosis and Treatment

Infertility diagnosis, treatment, and other ovulation enhancing treatments are sought after by residents of all races, gender identities, and sexual orientations. However, the high costs of services to diagnose, treat, and manage infertility disproportionately impact Black, Indigenous, Latine, and other residents of color, many of which identify as LGBTQ+. To date, most people in the US pay for infertility diagnosis and treatment out of pocket.[52]

A 2011 study on the cost of infertility treatment in North Carolina found that patients spent over $1,000 on medications alone, and patients that used IVF or other assisted reproductive technology treatments spent between $3,500 and about $38,000 (per person).[53] A later study by the American Society of Reproductive Medicine (ASRM) found that the average cost of one cycle of IVF was over $12,000 in 2015.[54] Recent reports share that IVF can cost between $10,000 and $25,000—depending on any additional health care needs a patient may have.[55]

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[48] Paula Amato. "Fertility Options for Transgender Persons." UCSF Transgender Care, June 17, 2016.
[49] Ibid.
[50] When CORE talks about "people of color," we are referring to Black, Indigenous, Latine, Asian American, Pacific Islander, and Native Hawaiian populations. We do so while acknowledging that each community of color has a unique history and experience of racism in the United States, and particularly, in the District of Columbia. While it is sometimes more efficient to reference "people of color" in narrative text, policies and actions must respond to the historical trauma each community has faced by naming individual communities.
[51] Tong, Michelle, and Samantha Artiga. "Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications." *KFF* (blog), December 9, 2021.
[52] Weigel, Gabriela, Usha Ranji, and Michelle Long. "Coverage and Use of Fertility Services in the U.S." Kaiser Family Foundation, September 15, 2020.
[53] Ibid.
[54] Insogna, Iris G., and Elizabeth S. Ginsburg. "Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy." AMA Journal of Ethics 20, no. 12 (December 1, 2018): 1152–59.
[55] Sabrina Malhi and Teddy Amenabar. "How Often Does IVF Succeed, and How Much Does It Cost?" The Washington Post, November 11, 2022, sec. Well+Being.

Importantly, cost has been named as one of the main reasons why people do not pursue infertility diagnosis and treatment.[56,57] It is within this context that CORE analyzes the bill's racial equity impacts.

RACIAL EQUITY IMPACTS

Bill 25-0034 will likely improve access to infertility treatments for Black, Indigenous, Latine, and other residents of color that have health insurance. However, cost may still remain a barrier for residents of color—including LGBTQ+ residents of color. As highlighted earlier, cost is a primary barrier to accessing fertility treatment.[58] This is especially true for Black, Indigenous, Latine, and other residents of color, who—due to systemic racism—are disproportionately more likely to experience infertility,[59] earn lower household incomes,[60] and be uninsured[61] when compared to white residents. Given that insurance will likely reduce the cost of treatment for people that would otherwise pay for services out of pocket, it will likely also improve access to fertility treatment. One study found that when cost is no longer a barrier, Black cisgender women's use of fertility treatments such as assisted reproductive technology increases over four times than when cost continues to be a barrier.[62] Another study focused on Black cisgender men's use of fertility treatment found that when insurance coverage is mandated for infertility treatment, Black cisgender men use fertility treatments as often as white cisgender men.[63]

However, this improved access also depends on Black, Indigenous, Latine, and other residents of color overcoming other barriers—such as disparities in quality of health care and the support of doctors—to access fertility treatment. This REIA's Further Considerations section explains this in more detail.

In addition, it is important to note that even for insured residents, accessing services can still be costly and difficult given insurance mechanisms for limiting or delaying coverage—such as deductibles, co-pays, and insurance premiums. While these costs are universal across all racial and ethnic groups, income inequities by race and ethnicity mean the costs create a greater financial burden for Black, Latine, and other people of color than for white people.

Research shows that white people are more likely than Latine and Black people to use and spend money on health care services[64]—likely because they have more income to spend and can more easily meet their deductibles, co-pays, and other required costs. In 2016, white people spent on average roughly $8,000 on health care services.[65] Black people spent $7,000, Latine people spent $6,000, and Indigenous[66] people spent

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[56] Weigel, Gabriela, Usha Ranji, and Michelle Long. "Coverage and Use of Fertility Services in the U.S." Kaiser Family Foundation, September 15, 2020.
[57] Insogna, Iris G., and Elizabeth S. Ginsburg. "Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy." AMA Journal of Ethics 20, no. 12 (December 1, 2018): 1152–59.
[58] Ibid.
[59] American Psychological Association. "Infertility and Black, Indigenous & People of Color," n.d.
[60] The MITRE Corporation. "The Racial Wealth Gap in Washington, D.C." The MITRE Corporation, December 2021.
[61] Kaiser Family Foundation. "Uninsured Rates for the Nonelderly by Race/Ethnicity," October 28, 2022; This data source did not provide uninsured percentages for residents that identify as Indigenous or Pacific Islander, nor for residents that identify with two or more races.
[62] Insogna, Iris G., and Elizabeth S. Ginsburg. "Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy." AMA Journal of Ethics 20, no. 12 (December 1, 2018): 1152–59.
[63] Najari, Bobby B. "Racial Differences in Men Seeking Fertility Treatment in North America: A Timely Report by the Andrology Research Consortium." Fertility and Sterility 116, no. 5 (November 2021): 1295–96.
[64] Dieleman JL, Chen C, Crosby SW, et al. "US Health Care Spending by Race and Ethnicity, 2002-2016." *JAMA.* 2021.
[65] Ibid.
[66] Although the data cited in this source uses the term "American Indian," CORE is using the term "Indigenous" throughout this REIA. For more on the term "Indigenous," please see Merriam-Webster.

$5,000—the three racial and ethnic groups to spend the least money on health care costs.[67] Notably, in the US, white people's median income that same year was $60,000—significantly higher than the median income of Black ($39,000), Latine ($47,000), and Indigenous ($40,000) people.[68] (These numbers include the incomes of people both with and without insurance.) This income gap is even greater in the District.[69] These inequities in income by race and ethnicity have historically made it more difficult for Black, Latine, and other people of color to meet their deductibles and use health care services, even when they have insurance coverage.

CORE commends the bill's inclusion of coverage for LGBTQ+ people and couples that may seek parenthood through procedures such as IVF—especially given that many jurisdictions do not include this. A 2019 study conducted by the Williams Institute at the UCLA School of Law indicated that about 10% of DC's population self-identifies as LGBTQ+, the highest percentage of self-identified LGBTQ+ persons within a given population in the country.[70] About 26% of DC's LGBTQ+ population is Black, 57% is white, and 17% identify as other races.[71]

Alongside this recognition, it is important to understand the barriers that LGBTQ+ people of color may face in pursing infertility treatment. Black and other LGBTQ+ people of color face well-documented challenges navigating the world with multiple identities that are marginalized and discriminated against in every major American institution.[72] Nearly half of LGBTQ+ people of color in the nation are considered having "low income," compared to 36% of white LGBTQ+ individuals.[73] The discrimination Black and other LGBTQ+ people of color face in the US[74,75] results in them being less likely to have access to quality health care, employment, housing, and education than their white LGBTQ+ peers.[76] For LGBTQ+ people of color, the compounding social stigma and structural discrimination they face can become exacerbated by seeking parenthood.[77] These are some factors that lead to heightened barriers for LGBTQ+ people seeking parenthood through procedures such as IVF, regardless of insurance coverage.

Bill 25-0034 maintains the status quo of access and affordability of infertility diagnosis and care for Black, Indigenous, Latine, and other residents of color without health insurance. Racial inequities in income and employment opportunities contribute to racial inequities in health care coverage and usage. This is especially true given that in the United States, access to health care and health insurance primarily relies on the ability to pay for care out of pocket or get insurance through an employer. For Black District

[67] Dieleman JL, Chen C, Crosby SW, et al. "US Health Care Spending by Race and Ethnicity, 2002-2016." *JAMA.* 2021.
[68] "S1903 Median Income In The Past 12 Months (In 2016 Inflation-Adjusted Dollars)" Census Bureau Table. 2016. Although the data cited in this source uses the terms "American Indian," CORE is using the term "Indigenous" throughout this REIA. For more on the term "Indigenous," please see Merriam-Webster.
[69] "Household Income." DC Health Matters. 2023.
[70] "LGBT Demographic Data Interactive." Los Angeles, CA: The Williams Institute, UCLA School of Law. January 2019.
[71] Ibid.
[72] Mahowald, Lindsay. "LGBTQ People of Color Encounter Heightened Discrimination." *Center for American Progress* (blog), June 24, 2021.
[73] The Williams Institute. "Race and Well-Being Among LGBT Adults." UCLA School of Law Williams Institute, n.d.
[74] Prichep, Deena. "For LGBTQ People Of Color, Discrimination Compounds." *NPR*, November 25, 2017, sec. You, Me And Them: Experiencing Discrimination In America.
[75] Kastanis, Angeliki. Gates, Gary J. "LGBT African-American Individuals and African-American Same-Sex Couples." Williams Institute, October 2013.
[76] Mahowald, Lindsay. "LGBTQ People of Color Encounter Heightened Discrimination." *Center for American Progress* (blog), June 24, 2021.
[77] Movement Advancement, et al. Project. "ALL CHILDREN MATTER: How Legal and Social Inequalities Hurt LGBT Families," October 2011 and The Movement Advancement Project. "LGBT Families of Color Facts at a Glance," January 2012.

residents in particular, racism has often limited employment opportunities to jobs with very few benefits, including limited health insurance benefits.[78]

Health insurance coverage in the District is relatively high when compared to the rest of the country. However, racial inequities exist in coverage rates: Latine[79] District residents faced the highest rate of not having insurance at 7.9%, followed by Black residents with a rate of 5.2%, and white residents with a rate of 1.6%.[80]

Bill 25-0034's reporting requirement for the Department of Health Care Finance will have an inconclusive impact on Black, Indigenous, Latine, and other residents of color. The bill requires the Department of Health Care Finance (DHCF) to research and report on the medical necessity of IVF and fertility preservation services (from the perspective of the federal law). This report is meant to be a step toward exploring coverage for these treatments via Medicaid. While the bill specifies that DHCF must complete this report within 180 days of the bill's passing, it does not include any mandated actions that must follow these findings and report.

To contextualize who could be impacted by this, it is important to note that a key eligibility requirement for health insurance through Medicaid is household income.[81] Black residents make up the highest percentage of those with Medicaid (48%), followed by residents that identify with multiple races (23%), Latine residents (19%), and Asian, Native Hawaiian, and Pacific Islander residents (6%).[82] This is in part due to systemic racism and the relentless denial of education, employment, and wealth-building opportunities to Black, Indigenous, Latine, and other residents of color—all of which contribute to lower incomes.[83]

These racial inequities in income, paired with the fact that Black, Latine, and Indigenous people experience higher rates of infertility, means that these residents could be most impacted by decisions that follow DHCF's report. However, because there is not a mandated action to follow this reporting and DC Medicaid does not currently cover these services, the racial equity impact of the report requirement is inconclusive.

FURTHER CONSIDERATIONS

The Center for Disease Control and Prevention's National Public Health Action Plan suggests that integrating fertility screening and treatment services into primary care settings can maximize fertility treatment outcomes.[84]

[78] The MITRE Corporation. "The Racial Wealth Gap in Washington, D.C." The MITRE Corporation, December 2021.
[79] Although the data cited throughout this REIA uses the term "Hispanic," CORE is using the term "Latine." Sources often use the term "Hispanic" because they rely on Census or other federal data which use the term "Hispanic" to collect data on people with ethnicities related to Spanish-speaking countries in Latin America and Spain. However, most "Hispanics" in the United States and the District are people with ethnicities from Latin America (also known as Latine)—and not Spain. The term "Hispanic" does not fully acknowledge the unique history of oppression and colonialism that Latines have faced in the United States and the District. To recognize this history, CORE uses the term "Latine" instead of "Hispanic" when not directly referencing a source. For more on this topic, see Lopez, Mark Hugo, Jens Manuel Krogstad, and Jeffrey S. Passel. "Who Is Hispanic?" *Pew Research Center*.
[80] Kaiser Family Foundation. "Uninsured Rates for the Nonelderly by Race/Ethnicity," October 28, 2022; This data source did not provide uninsured percentages for residents that identify as Indigenous or Pacific Islander, nor for residents that identify with two or more races.
[81] DC Department of Health Care Finance. "How to Qualify for DC Medicaid?," n.d.
[82] Kaiser Family Foundation. "Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity." KFF, October 28, 2022. This data source did not provide percentages for residents that identify as Indigenous.
[83] D.C. Policy Center. "DC Racial Equity Profile." Council Office of Racial Equity, 2021.
[84] Centers for Disease Control and Prevention. "National Public Health Action Plan for the Detection, Prevention, and Management of Infertility." U.S. Department of Health and Human Services, June 2014.

Bill 25-0034 does not mandate action following the Department of Health Care Finance's research and report on the medical necessity for IVF and standard fertility preservation services. The bill takes an important step toward Medicaid coverage for these procedures and services by requiring the Department of Health Care Finance (DHCF) to research and report on the medical necessity for IVF and standard fertility preservation services (from the perspective of the federal law). However, there is no required action following this report. This means that if this bill is passed, those with Medicaid may not get coverage for IVF and fertility preservation services, even if DHCF finds that these services are considered medically necessary under federal law.

The Council should consider ways that it can mandate actionable steps following DHCF's report to ensure that residents with Medicaid coverage—half of which are Black residents—get similar coverage for IVF and fertility preservation services as white residents (whose incomes and jobs make access to such coverage more attainable due to the cost of private health insurance).

Without an intentional focus on the ways in which racism has been engrained into obstetrics, gynecology, midwifery, endocrinology, and the health care system broadly, improvements in fertility and birth outcomes could potentially be minimal for Black residents. Ultimately, requiring health insurance coverage of the diagnosis and treatment of infertility in the District may increase the number of people that seek these services. However, the racial inequities that Black residents experience prior to, during, and after birth still exist—and fertility diagnosis and treatment services are offered within this medically racist context.

For example, research on racial and ethnic disparities in pregnancy-related deaths has shown that "most pregnancy-related deaths are preventable."[85] Despite this, Black people that give birth in DC face a birth mortality rate—meaning a certain number of deaths related to giving birth out of 100,000 live births—that is more than double the national average. Even further, Black people giving birth in the District have a birth mortality rate that is almost double than the overall birth mortality rate of all DC residents.[86]

The research in this REIA highlights that improvements in access to fertility treatment are crucially important for Black residents. However, these benefits cannot be fully achieved without addressing the medical racism that Black residents experience most violently and frequently in comparison to other District residents.

ASSESSMENT LIMITATIONS

Alongside the analysis provided above, the Council Office of Racial Equity encourages readers to keep the following limitations in mind:

We generally do not provide policy solutions or alternatives to address our racial equity concerns. While Council Period 25 Rules allow our office to make policy recommendations, we focus on our role as policy analysts—we are not elected policymakers or committee staff. In addition, and more importantly, racially equitable policymaking takes time. Because we only have ten days for our review, we would need more time to ensure comprehensive research and thorough community engagement inform our recommendations.

[85] Centers for Disease Control and Prevention. "Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths." CDC, September 6, 2019.
[86] Marcella Robertson. "DC Councilwoman Fights to Reduce Maternal Mortality." WUSA9, April 16, 2021.

Assessing legislation's potential racial equity impacts is a rigorous, analytical, and organized undertaking—but it is also an exercise with constraints. It is impossible for anyone to predict the future, implementation does not always match the intent of the law, critical data may be unavailable, and today's circumstances may change tomorrow. Our assessment is our most educated and critical hypothesis of the bill's racial equity impacts.

Regardless of the Council Office of Racial Equity's final assessment, the legislation can still pass. This assessment intends to inform the public, Councilmembers, and Council staff about the legislation through a racial equity lens. However, a REIA is not binding.

This assessment aims to be accurate and useful, but omissions may exist. Given the density of racial equity issues, it is unlikely that we will raise *all* relevant racial equity issues present in a bill. In addition, an omission from our assessment should not: 1) be interpreted as a provision having no racial equity impact or 2) invalidate another party's racial equity concern.

ATTACHMENT
E

Government of the District of Columbia
Office of the Chief Financial Officer

Glen Lee
Chief Financial Officer

MEMORANDUM

TO:	**The Honorable Phil Mendelson** **Chairman, Council of the District of Columbia**
FROM:	**Glen Lee** **Chief Financial Officer**
DATE:	**May 30, 2023**
SUBJECT:	**Fiscal Impact Statement – Expanding Access to Fertility Treatment Amendment Act of 2023**
REFERENCE:	**Bill 25-34, Draft Committee Print as provided to the Office of Revenue Analysis on May 24, 2023**

Conclusion

Funds are not sufficient in the fiscal year 2023 budget and proposed fiscal year 2024 through fiscal year 2027 budget and financial plan to implement the bill. The total cost of the bill is $1.69 million in fiscal year 2024 and $13 million over the financial plan. There are no costs in fiscal year 2023.

The proposed fiscal year 2024 budget includes $1.69 million ($750,000 local; $940,000 federal) and $3.05 million ($1.36 million local; $1.67 million federal) over the financial plan to implement Medicaid and D.C. Healthcare Alliance[1] coverage of infertility diagnosis and medically necessary ovulation enhancing drugs as well as to pay the Department of Insurance, Securities and Banking's (DISB) costs under the bill. However, additional funding is needed at the Health Benefit Exchanged to implement infertility diagnosis and treatment coverage mandates for private health insurance providers.[2]

Background

The bill requires Medicaid, the Health Care Alliance (Alliance), and private insurers to provide coverage for diagnosis and treatment of infertility.

Beginning January 1, 2024, Medicaid and the Alliance must provide coverage for the diagnosis of infertility and any medically necessary ovulation enhancing drugs and medical services related to

[1] Amendatory Section 5f(c).
[2] Amendatory Section 5f(b).

prescribing and monitoring the use of such drugs, including at least three cycles of ovulation-enhancing medication treatment over an enrollee's lifetime.

The bill directs the Department of Health Care Finance (DHCF) to prepare a report on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in vitro fertilization and standard fertility preservation services including any potentially applicable waiver authorities, and the costs that would need to be allocated against federal and local funds for such coverage, under both Medicaid fee-for-service and managed care organization plans. DHCF must provide its report to Council within 180 days of the effective date of the bill.

Beginning January 1, 2025, private health insurers offering large group health plans, small group health plans, and individual health plans must provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services.[3] The bill also prohibits private health insurers from:

- Imposing deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for the diagnosis and treatment of infertility, including treating the prescription of fertility medications different from those imposed upon benefits for services not related to infertility;
- Placing pre-existing condition exclusions or waiting periods on coverage for the treatment of infertility, or using prior treatment for infertility as a basis for excluding, limiting, or otherwise restricting coverage; and
- Limiting coverage, providing different benefits, or imposing different requirements for fertility treatment based solely on arbitrary factors including number of attempts, dollar amounts, age, or upon a class protected under the Human Rights Act.

Financial Plan Impact

Funds are not sufficient in the fiscal year 2023 budget and proposed fiscal year 2024 through fiscal year 2027 budget and financial plan to implement the bill. The total cost of the bill is $1.69 million in fiscal year 2024 and $13 million over the financial plan. There are no costs in fiscal year 2023.

The proposed fiscal year 2024 budget includes $1.69 million ($750,000 local; $940,000 federal) and $3.05 million ($1.36 million local; $1.67 million federal) over the financial plan to implement Medicaid and Alliance coverage of infertility diagnosis and medically necessary ovulation enhancing drugs as well as to pay DISB's costs under the bill. However, additional funding is needed at the Health Benefit Exchange to implement infertility diagnosis and treatment coverage mandates for private health insurance providers. The chart below summarizes the bill's total costs, while additional details on the components are described below the chart.

[3] Including at least three complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer when recommended and medically appropriate. An oocyte is a cell in an ovary which may undergo meiotic division to form an ovum.

B25-34– Expanding Access to Fertility Treatment Amendment Act of 2023 Total Cost (in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
DHCF - Local	$700	$194	$208	$223	$1,325
DCHF - Federal	$940	$240	$244	$248	$1,672
Department of Insurance, Securities and Banking	$50	$0	$0	$0	$50
Health Benefit Exchange	$0	$2,662	$3,610	$3,671	$9,943
Total	$1,690	$3,096	$4,062	$4,142	$12,990

Medicaid and the Alliance

District Medicaid coverage already includes diagnosis of infertility but does not cover ovulation enhancing drugs. DHCF used beneficiary claims data to estimate that approximately 215 Medicaid beneficiaries will use ovulation enhancing drugs during the first year of coverage. After pent-up demand subsides after year one, DHCF anticipates that approximately 50 beneficiaries will use ovulation enhancing drugs on an annual basis. The total cost of Medicaid coverage of ovulation enhancing drugs is $1.34 million ($403,000 Local; $940,000 Federal) in fiscal year 2024 and $2.41 million over the financial plan. This funding has been included in the proposed fiscal year 2024 budget and financial plan.

The diagnosis of infertility and use of ovulation enhancing drugs is not covered by the Alliance . There are certain services associated with infertility that are captured in Alliance claims data that were used by DHCF to estimate how many individuals would use these services. DHCF estimates that 180 Alliance beneficiaries will likely be diagnosed with infertility in year one and around 50 beneficiaries will be diagnosed each year after pent-up demand subsides after the first year of coverage. DHCF estimates that 20 percent of these members will use ovulation enhancing drugs to treat infertility issues. The total cost to the Alliance program of covering diagnosis of infertility and use of ovulation enhancing drugs is $297,000 in fiscal year 2024 and $591,000 over the financial plan. The proposed fiscal year 2024 budget and financial plan includes sufficient funding to implement this Alliance coverage.

B25-34 – Expanding Access to Fertility Treatment Amendment Act of 2023 Total Medicaid and Alliance Costs (in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Medicaid Total Cost - Ovulation Enhancing Drugs[(a)]	$1,343	$343	$354	$366	$2,406
- *Local Portion[(b)]*	*$403*	*$103*	*$110*	*$118*	*$734*
- *Federal Portion[(c)]*	*$940*	*$240*	*$244*	*$248*	*$1,672*
Alliance Ovulation Enhancing Drugs[(d)]	$280	$73	$78	$84	$515
Alliance Infertility Diagnosis Coverage[(e)]	$17	$18	$20	$21	$76
Total Cost[(f)]	$1,640	$434	$452	$471	$2,997

Table Notes:

(a) Assumes average course of treatment cost of $3,000 and three treatment cycles per individual using ovulation enhancing drugs.
(b) Assumes 30 percent local share.

(c) Assumes 70 percent federal share.
(d) Assumes average course of treatment cost of $3,000 and three treatment cycles per individual using ovulation enhancing drugs.
(e) Assumes $58 cost per member seeking an infertility diagnosis.
(f) Assumes higher demand in fiscal year 2024 and annual cost growth of 1.7 percent.

Private Health Insurance Market

The Affordable Care Act requires states to establish Essential Health Benefits (EHB) that all Qualified Health Plans (QHP) in the individual and small group market (DC Health Link) must cover. Benefits mandated by the District after January 1, 2012 are considered additional health benefits.[4] Federal law requires the District to make payments to defray the cost of additional required benefits by either paying enrollees directly or by paying QHPs on behalf of enrollees. Each QHP in the District must quantify the cost attributable to an additional required benefit.

The bill's mandate for private insurers to provide coverage for the diagnosis and treatment of infertility (including in vitro fertilization and standard fertility preservation services) will require the District to make defrayal payments to QHPs in the individual and small group market.[5] The Office of Revenue Analysis estimates that defrayal payments will cost $2.66 million in fiscal year 2025 and $9.94 million over the financial plan. The final cost of defrayal payments will be provided in the DISB actuary study described below. Defrayal payments will be administered by the Health Benefit Exchange Authority and payments will be made directly to QHPs on behalf of enrollees.

B25-34 - Expanding Access to Fertility Treatment Amendment Act of 2023 Total Defrayal Costs (in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Defrayal Cost	0	$2,663	$3,610	$3,671	$9,944

Table Notes
(a) Assumes January 1, 2025 start date.
(b) Assumes 15,000 individual market enrollees and 87,000 small group enrollees.
(c) Assumes annual cost increase of $34.80 per enrollee and cost growth of 1.7 percent.

The Department of Insurance, Securities and Banking (DISB) reviews health insurance rate filings to determine if rate changes submitted by QHPs will be approved, disapproved, or rejected before the plan is released into the District's health insurance marketplace. DISB must hire an actuary to project the actual amount of money that must be budgeted to defray the cost of additional benefits. DISB must also contract with a subject matter expert in order to establish regulations governing defrayal payments. The total cost of contracting with an actuary and a subject matter expert is $50,000 in fiscal year 2024. The proposed fiscal year 2024 budget and financial plan includes sufficient funding to contract with an actuary and a subject matter expert. The fiscal impact of defrayal costs will be updated to incorporate DISB actuary projections when they become available.

[4] 45 CFR 155.170(c)(2)(iii).
[5] Large group health plans are not required to cover EHBs and do not participate in the District's health benefit exchange.

B25-34 – Expanding Access to Fertility Treatment Amendment Act of 2023 Total DISB Costs (in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Subject Matter Expert	$20	$0	$0	$0	$20
Actuary	$30	$0	$0	$0	$30
Total	$50	$0	$0	$0	$50

It is possible the bill's requirements may impact prices of large group health plans such as those provided to District government employees. Any increases in premiums due to the bill's requirements may increase the cost of the District's portion of employee's insurance premiums. Health plans currently offered to District employees include some coverage for fertility treatment, but the impact of the bill's specific provisions regarding deductibles, co-payments, co-insurance, benefit maximums and other limitations is unknown at this time.

ATTACHMENT
F

OFFICE OF THE GENERAL COUNSEL
Council of the District of Columbia
1350 Pennsylvania Avenue NW, Suite 4
Washington, DC 20004
(202) 724-8026

MEMORANDUM

TO: **Councilmember Christina Henderson**

FROM: **Nicole L. Streeter, General Counsel NLS**

DATE: **May 30, 2023**

RE: **Legal sufficiency determination for Bill 25-34, the Expanding Access to Fertility Treatment Amendment Act of 2023**

The measure is legally and technically sufficient for Council consideration.

The measure would amend the Women's Health and Cancer Right Federal Law Conformity Act of 2000[1] to require health insurers offering certain health benefit plans[2] and Medicaid and the DC Healthcare Alliance to provide coverage for infertility, including vitro fertilization and fertility preservation by specified dates.

I am available if you have any questions.

[1] Effective April 3, 2001 (D.C. Law 13-254; D.C. Official Code § 31-3831 *et seq.*).
[2] Defined in § 31-3831(6).

ATTACHMENT
G

Comparative Committee Print
Committee on Health
B25-34
May 31, 2023

Section 2

D.C. Official Code § 31-3834.04. Religious exemption and accommodation.

(a)(1) An employer organized and operating as a nonprofit entity and referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, approved October 22, 1986 (100 Stat. 2740; 26 U.S.C. § 6033(a)(3)(A)(i) or (iii)), may be exempt from any requirement to cover contraceptive ~~**drugs, devices, products, and services under §§ 31-3834.01, 31-3834.02, and 31-3834.03**~~ **or fertility enhancing drugs, devices, products, and services under sections §§ 31.3834.01, 31.3834.02, 31.3834.03, and 31.3834.06.**

(2) An employer claiming an exemption under this subsection shall provide its employees and prospective employees reasonable and timely notice of the exemption before enrollment with the group health plan, and the notice shall list the contraceptive drugs, devices, products, and services for which the employer does not provide coverage.

(3) Nothing in this subsection shall be construed to allow for the exclusion of coverage for contraceptive drugs, devices, products, and service as prescribed by a provider, acting within his or her scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraceptive drugs, devices, products, and services that are necessary to preserve the life or health of an enrollee.

(b)(1) Nothing in this chapter shall be construed to require an employer to provide coverage for contraceptive drugs, devices, products, and services through its group health plan if the employer has provided to its group health insurance issuer a notice of request for accommodation, in a form and manner specified by the Mayor, and the insurer has certified that the employer meets the requirements of subsection (c) of this section.

(2) Beginning on January 1, 2019, and on a quarterly basis thereafter, a group health insurance issuer shall notify the Department of Insurance, Securities, and Banking which employers have been granted an accommodation pursuant to subsection (c) of this section.

(3) An employer that receives an accommodation pursuant to subsection (c) of this section shall provide, through its group health plan, coverage for contraceptive drugs, devices, products, and services as prescribed and dispensed by a provider, acting within her or her scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, and for contraceptive drugs, devices, products, and services that are necessary to preserve the life or health of an enrollee.

(c) A group health insurance issuer shall provide an employer with an accommodation to the requirements of § 31-3834.01, § 31-3834.02, ~~**or § 31-3834.03**~~ **§ 31-3834.03, or § 31-3834.06**

upon receipt of a self-certification, in a form and manner specified by the Mayor, that the employer is:

(1) A nonprofit entity that holds itself out as a religious organization and objects to covering some or all of the ~~**contraceptive drugs**~~ **contraceptive or fertility enhancing drugs**, devices, products, or services on account of its sincerely held religious beliefs; or

(2) A closely-held for-profit entity; provided, that its highest governing body (such as its board of directors, board of trustees, or owners, if managed directly by its owners) has adopted a resolution or similar action establishing that it objects to covering some or all of the ~~**contraceptive drugs**~~ **contraceptive or fertility enhancing drugs**, devices, products, or services on account of the owners' sincerely held religious beliefs.

(d) Upon receipt of a notice of request for accommodation that conforms to the requirements of subsection (c) of this section, a group health insurance issuer shall:

(1) Exclude ~~**contraceptive drugs**~~ **contraceptive or fertility enhancing drugs**, devices, products, or services coverage from the group health insurance coverage provided in connection with the employer's group health plan; and

(2) Provide separate payments for any contraceptive ~~**drugs, devices, products, or services required to be covered under § 31-3834.01, § 31-3834.02, or § 31-3834.03**~~ **or fertility enhancing drugs, devices, products, and services under § 31-3834.01, § 31-3834.02, § 31-3834.03, and § 31-3834.06** without imposing any cost-sharing requirements or any other fee directly or indirectly on the employer, the group health plan, or plan participants or beneficiaries.

(e) For the purposes of this section, the term "closely-held for-profit entity" means an entity that:

(1) Is not a nonprofit entity;

(2) Has no publicly traded ownership interests of any class of common equity securities required to be registered under section 12 of the Securities Exchange Act of 1934, approved June 6, 1934 (48 Stat. 892; 15 U.S.C. § 78l); and

(3) Has more than 50% of the value of its ownership interest owned directly or indirectly by 5 or fewer individuals, or has an ownership structure that is substantially similar thereto, as of the date of the entity's self-certification pursuant to subsection (c) of this section.

D.C. Official Code § 31-3834.06. Coverage of fertility treatments.

(a)(1) Beginning January 1, 2025, a health insurer offering a large group health benefit plan shall provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services, as provided in paragraph (2) of this subsection; provided that the treatment would be consistent with a physician's or surgeon's overall plan of care.

(2) The health benefit plan shall cover:

(A) At least 3 complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval performed prior to January 1, 2025, in accordance with the guidelines of ASRM, using single embryo transfer when recommended and medically appropriate; and

(B) The medical costs related to an embryo transfer to be made from an enrollee to a third-party; except that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

(b)(1) Beginning January 1, 2025, a health insurer offering an individual health benefit plan or small group health plan shall provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services, as provided in paragraph (2) of this subsection; provided that the treatment would be consistent with a physician's or surgeon's overall plan of care.

(2) The health benefit plan shall cover:

(A) At least 3 complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval performed prior to Janaury 1, 2025, in accordance with the guidelines of ASRM, using single embryo transfer when recommended and medically appropriate; and

(B) The medical costs related to an embryo transfer to be made from an enrollee to a third-party; except that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

(c) Beginning January 1, 2024, health insurance coverage through Medicaid and the DC Healthcare Alliance program shall provide coverage for the diagnosis of infertility and any medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, which shall include at least 3 cycles of ovulation-enhancing medication treatment over an enrollee's lifetime.

(d) Within 180 days of the effective date of this section, the Department of Health Care Finance shall submit a report to the Council after consulting with the Centers for Medicare & Medicaid Services on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit for both fee-for-service and managed care organizations including any potentially applicable waiver authorities, and the amount of money that would need to be allocated to federal and local funds for such coverage.

(e) Coverage for the treatment of infertility shall be provided without discrimination on the basis of age, ancestry, disability, domestic partner status, gender, gender expression,

gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

(f) A health insurer shall not impose:

(1) Deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for the diagnosis and treatment of infertility, including the prescription of fertility medications, different from those imposed upon benefits for services not related to infertility;

(2) Pre-existing condition exclusions or pre-existing condition waiting periods on coverage for the diagnosis and treatment of infertility or use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting, or otherwise restricting the availability of coverage for required benefits; or

(3) Limitations on coverage based solely on arbitrary factors, including number of attempts, dollar amounts, or age, or provide different benefits to, or impose different requirements upon, a class protected under the Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 2-38; D.C. Official Code § 2-1401.01 *et seq.*), than that provided to, or required of, other patients.

(g) Nothing in this section shall be construed to interfere with the clinical judgment of a physician or surgeon.

(h) The health insurer shall notify all policyholders and all prospective group policyholders with whom they are negotiating of the availability of coverage provided under this section.

(i) For the purposes of this section, the term:

(1) "ASRM" means the American Society for Reproductive Medicine.

(2) "Infertility" means a disease, condition, or status characterized by:

(A) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse in accordance with the guidelines of ASRM;

(B) A person's inability to reproduce without medical intervention either as a single individual or with their partner; or

(C) A licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

(3) "Treatment for infertility" means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons, including diagnosis, diagnostic tests, medication, surgery, or gamete intrafallopian transfer.

(4) "Standard fertility preservation services" means procedures that are consistent with established medical practices or professional guidelines published by ASRM or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

(j) The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq*.), shall issue rules to implement the provisions of this section.

ATTACHMENT
H

Committee Print
Committee on Health
B25-34
May 31, 2023

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Women's Health and Cancer Rights Federal Law Conformity Act of 2000 to require an individual or group plan to provide coverage for the diagnosis and treatment of infertility and standard fertility preservation services, and to require a health insurer offering health insurance coverage through Medicaid and the DC Healthcare Alliance program to cover the diagnosis and medication treatment of infertility.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Expanding Access to Fertility Treatment Amendment Act of 2023".

Sec. 2. The Women's Health and Cancer Rights Federal Law Conformity Act of 2000, effective April 3, 2001 (D.C. Law 13-254; D.C. Official Code § 31-3831 *et seq.*), is amended as follows:

(a) Section 5d (D.C. Official Code § 31-3834.04) is amended as follows:

(1) Subsection (a)(1) is amended by striking the phrase "drugs, devices, products, and services under sections 5a, 5b, and 5c." and inserting the phrase "or fertility enhancing drugs, devices, products, and services under sections 5a, 5b, 5c, and 5f." in its place.

(2) Subsection (c) is amended as follows:

(A) The lead-in language is amended by striking the phrase ", or 5c" and inserting the phrase ", 5c, or 5f" in its place.

(B) Paragraph (1) is amended by striking the phrase "contraceptive drugs" and inserting the phrase "contraceptive or fertility enhancing drugs" in its place.

(C) Paragraph (2) is amended by striking the phrase "contraceptive drugs" and inserting the phrase "contraceptive or fertility enhancing drugs" in its place.

(3) Subsection (d) is amended as follows:

(A) Paragraph (1) is amended by striking the phrase "contraceptive drugs" and inserting the phrase "contraceptive or fertility enhancing drugs" in its place.

(B) Paragraph (2) is amended by striking the phrase "drugs, devices, products, and services under section 5a, 5b, and 5c." and inserting the phrase "or fertility enhancing drugs, devices, products, and services under section 5a, 5b, 5c, and 5f." in its place.

(b) A new section 5f is added to read as follows:

"Sec. 5f. Coverage of fertility treatments.

"(a)(1) Beginning January 1, 2025, a health insurer offering a large group health benefit plan shall provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services, as provided in paragraph (2) of this subsection; provided that the treatment would be consistent with a physician's or surgeon's overall plan of care.

"(2) The health benefit plan shall cover:

"(A) At least 3 complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval performed prior to January 1, 2025, in

accordance with the guidelines of ASRM, using single embryo transfer when recommended and medically appropriate; and

"(B) The medical costs related to an embryo transfer to be made from an enrollee to a third-party; except that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

"(b)(1) Beginning January 1, 2025, a health insurer offering an individual health benefit plan or small group health plan shall provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization and standard fertility preservation services, as provided in paragraph (2) of this subsection; provided that the treatment would be consistent with a physician's or surgeon's overall plan of care.

"(2) The health benefit plan shall cover:

"(A) At least 3 complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval performed prior to January 1, 2025, in accordance with the guidelines of ASRM, using single embryo transfer when recommended and medically appropriate; and

"(B) The medical costs related to an embryo transfer to be made from an enrollee to a third-party; except that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

"(c) Beginning January 1, 2024, health insurance coverage through Medicaid and the DC Healthcare Alliance program shall provide coverage for the diagnosis of infertility and any medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, which shall include at least 3 cycles of ovulation-enhancing medication treatment over an enrollee's lifetime.

"(d) Within 180 days of the effective date of this section, the Department of Health Care Finance shall submit a report to the Council after consulting with the Centers for Medicare & Medicaid Services on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit for both fee-for-service and managed care organizations, including any potentially applicable waiver authorities, and the amount of money that would need to be allocated to federal and local funds for such coverage.

"(e) Coverage for the treatment of infertility shall be provided without discrimination on the basis of age, ancestry, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

"(f) A health insurer shall not impose:

"(1) Deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for the diagnosis and treatment of infertility, including the prescription of fertility medications, different from those imposed upon benefits for services not related to infertility;

"(2) Pre-existing condition exclusions or pre-existing condition waiting periods on coverage for the diagnosis and treatment of infertility or use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting, or otherwise restricting the availability of coverage for required benefits; or

"(3) Limitations on coverage based solely on arbitrary factors, including number of attempts, dollar amounts, or age, or provide different benefits to, or impose different

requirements upon, a class protected under the Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 2-38; D.C. Official Code § 2-1401.01 *et seq*.), than that provided to, or required of, other patients.

"(g) Nothing in this section shall be construed to interfere with the clinical judgment of a physician or surgeon.

"(h) The health insurer shall notify all policyholders and all prospective group policyholders with whom they are negotiating of the availability of coverage provided under this section.

"(i) For the purposes of this section, the term:

"(1) "ASRM" means the American Society for Reproductive Medicine.

"(2) "Infertility" means a disease, condition, or status characterized by:

"(A) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse in accordance with the guidelines of ASRM;

"(B) A person's inability to reproduce without medical intervention either as a single individual or with their partner; or

"(C) A licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

"(3) "Treatment for infertility" means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons, including diagnosis, diagnostic tests, medication, surgery, or gamete intrafallopian transfer.

"(4) "Standard fertility preservation services" means procedures that are consistent with established medical practices or professional guidelines published by ASRM or the American Society of Clinical Oncology for a person who has a medical condition or is

expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

"(j) The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq*.), shall issue rules to implement the provisions of this section.".

Sec. 3. Applicability.

"(a) Amendatory section 5f(b) in section 2 shall apply upon the date of inclusion of its fiscal effect in an approved budget and financial plan.

"(b) The Chief Financial Officer shall certify the date of the inclusion of the fiscal effect in an approved budget and financial plan and provide notice to the Budget Director of the Council of the certification.

"(c)(1) The Budget Director shall cause the notice of the certification to be published in the District of Columbia Register.

"(2) The date of publication of the notice of the certification shall not affect the applicability of this act.

Sec. 4. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 5. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December

24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.